PREPARTICIPATION PHYSICAL EVALUATION <> HISTORY FORM

DATE OF EXAM: _____/_____/_____

NAME: _____ SEX: _____ AGE: _____ DATE OF BIRTH: _____/_____/_____

GRADE: _____ SPORTS: _____

ADDRESS: _____ PHONE: ( ) _____

PERSONAL PHYSICIAN: _____

In case of emergency, contact:

NAME: _____ RELATIONSHIP: _____ P| PHONE: ( ) _____

	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason ?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have your ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have your ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection	☐	☐
10. Has a doctor ever orderd a test for your heart? (for example: ECG, echocardiogram)	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If "YES", circle below:	☐	☐
HEAD NECK SHOULDER UPPER ARM ELBOW FOREARM HAND / FINGERS CHEST UPPER BACK LOWER BACK HIP THIGH KNEE CALF / SHIN ANKLE FOOT / TOES		
18. Have you had any broken or fractured bones or dislocated joints? If "YES", circle below:	☐	☐
HEAD NECK SHOULDER UPPER ARM ELBOW FOREARM HAND / FINGERS CHEST UPPER BACK LOWER BACK HIP THIGH KNEE CALF / SHIN ANKLE FOOT / TOES		
19. Have you had a bone or joint injury that required x-rays, surgery, injections, rehabilitation, physical therapy, a cast, MRI, CT, a brace, or crutches? If "YES", circle below:	☐	☐
HEAD NECK SHOULDER UPPER ARM ELBOW FOREARM HAND / FINGERS CHEST UPPER BACK LOWER BACK HIP THIGH KNEE CALF / SHIN ANKLE FOOT / TOES		
20. Have you ever had a stress fracture?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoazial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you had a herpes skin infection?	☐	☐
31. Have you ever had a head injury or concussion?	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33. Have you ever had a seizure?	☐	☐
34. Do you have headaches with exercise?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
FEMALES ONLY		
47. Have you ever had a menstrual period?	☐	☐

48. How old were you when you had your 1st menstrual period? _____

49. How many periods have you had in the last 12 months? _____

EXPLAIN "YES" ANSWERS HERE:

_____

_____

_____

_____

_____

I herby state that, the the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete _____ DATE: _____

Signature of Parent / Guardian _____ DATE: _____