

## PRE-PARTICIPATION PHYSICAL EVALUATION



## HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart for their records).					
Date of Exam:					
Name: Date of Birth:					
Sex: Age: Grade: School: Sport(s):					
Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:					
·					
Do you have any allergies: Yes  No  If yes, please identify specific allergy below:					
☐ Medicines: ☐ Pollens:	ic allergy	Delow.	☐ Food: ☐ Stinging Insects:		
	alaw C	ivala a	estions you do not know the answer to.		
GENERAL QUESTIONS	Yes	No No	MEDICAL QUESTIONS	Yes	No
Has a doctor ever denied or restricted your participation in sports for	162	NO	26. Do you cough, wheeze, or have difficulty breathing during or after	169	NO
any reason?			exercise?		
2. Do you have any ongoing medical conditions? If so, please identify			27. Have you ever used an inhaler or taken asthma medicine?		
below: ☐Asthma ☐Anemia ☐Diabetes ☐Infections			28. Is there anyone in your family who has asthma?		
Other:			29. Were you born without or are you missing a kidney, an eye, a testicle		
Have you ever spent the night in the hospital?			(males) or spleen, or any other organ?		
4. Have you ever had surgery?			30. Do you have groin pain or a painful bulge or hernia in the groin area?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	31. Have you had infectious mononucleosis (mono) within the last month?		
5. Have you ever passed out or nearly passed out DURING or AFTER			32. Do you have any rashes, pressure sores, or other skin problems?		
exercise?			33. Have you had a herpes or MRSA skin infection?		1
<ol><li>Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?</li></ol>			34. Have you ever had a head injury or concussion?		+
Does your heart ever race or skip beats (irregular beats) during			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headaches, or memory problems?		
exercise?			36. Do you have a history of seizure disorder?		+
8. Has a doctor ever told you that you have any heart problems? If so,			37. Do you have headaches with exercise?		+
check all that apply:			38. Have you ever had numbness, tingling, or weakness in your arms or		
☐ High blood pressure ☐ A heart murmur ☐ A heart infection			legs after being hit or falling?		
☐ High cholesterol ☐ Kawasaki disease ☐ Other:			39. Have you ever been unable to move your arms or legs after being hit		
9. Has a doctor ever ordered a test for your heart? (For example,			or falling?		
ECG/EKG, echocardiogram)			40. Have you ever become ill while exercising in the heat?		4
10. Do you get lightheaded or feel more short of breath than expected			41. Do you get frequent muscle cramps when exercising?		1
during exercise?  11. Have you ever had an unexplained seizure?			Do you or someone in your family have sickle cell trait or disease?      Have you had any problems with your eyes or vision?		+
12. Do you get more tired or short of breath more quickly than your friends			44. Have you had any eye injuries?		+
during exercise?			45. Do you wear glasses or contact lenses?		1
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	46. Do you wear protective eyewear, such as goggles or a face shield?		†
13. Has any family member or relative died of heart problems or had an			47. Do you worry about your weight?		
unexpected or unexplained sudden death before age 50 (including			48. Are you trying to or has anyone recommended that you gain or lose		
drowning, unexplained car accident, or sudden infant death			weight?		
syndrome)?			49. Are you on a special diet or do you avoid certain types of foods?		
<ol> <li>Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT</li> </ol>			50. Have you ever had an eating disorder?		
syndrome, short QT syndrome, Brugada syndrome, or			51. Do you have any concerns that you would like to discuss with the doctor?		
catecholaminergic polymorphic ventricular tachycardia?			FEMALES ONLY	Yes	No
15. Does anyone in your family have a heart problem, pacemaker, or			52. Have you ever had a menstrual period?	100	140
implanted defibrillator?			53. How old were you when you had your first menstrual period?		
16. Has anyone in your family had unexplained fainting, unexplained			54. How many periods have you had in the last 12 months?		
seizures, or near drowning?	.,		Full-1: (W. all and a large	•	
BONE AND JOINT QUESTIONS	Yes	No	Explain "Yes" answers here:		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?					
Have you ever had any broken or fractured bones or dislocated joints?					
19. Have you ever had an injury that required x-rays, MRI, CT scan,					
injections, therapy, a brace, a cast, or crutches?					
20. Have you ever had a stress fracture?					
21. Have you ever been told that you have or have you had an x-ray for					
neck instability or atlantoaxial instability? (Down syndrome or					
dwarfism)	-				
22. Do you regularly use a brace, orthotics, or other assistive device?					
23. Do you have a bone, muscle, or joint injury that bothers you?	-				
<ol> <li>Do any of your joints become painful, swollen, feel warm, or look red?</li> <li>Do you have any history of juvenile arthritis or connective tissue</li> </ol>	1				
disease?					
I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.					
Signature of Athlete: Signature of Parent(s) or Guardian: Date:					
-			- ''	1	