Preparticipation Physical Examination **HISTORY FORM**

Date of Exam _____

Name_____ Sex _____ Age _____ Date of Birth _____
Grade _____ School _____Sport (s) _____
Address _____Phone _____
Personal Physician _____
In case of emergency, contact:
Name _____Relationship _____Phone (H) _____ (W) _____

Explain "Yes" answers below.
Circle questions you don't know the answer to.

		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 over-the counter medicines or pills?	___	___
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	___	___
5.	Have you ever passed out or nearly passed out DURING exercise?	___	___
6.	Have you 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 ordered a test for your heart? (ex. 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 a family member died of heart problems or of sudden death before 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 tendonitis, that caused you to miss a practice/game? If yes, circle affected area below:	___	___
18.	Have you had any broken or fracture bones or dislocated joints? If yes, circle below:	___	___
19.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabiliation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	___	___
20.	Have you ever had a stress fracture?	___	___
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (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 with 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 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 had a head injury/concussion?	___	___
32.	Have you been hit in the head & been confused or lost 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 arms or legs after being hit?	___	___
36.	Have you ever been unable to move arms or legs after being hit?	___	___
37.	When exercising in the heat, do you have severe muscle cramps or become ill?	___	___
38.	Has a doctor told you that you or a family member has sickle cell trait/disease?	___	___
39.	Have you had eye or vision problems?	___	___
40.	Do you wear glasses or contacts?	___	___
41.	Do you wear protective eyewear, such as goggles or face shield?	___	___
42.	Are you happy with your weight?	___	___
43.	Are you trying to lose or gain weight?	___	___
44.	Has anyone recommended you change weight or eating habits?	___	___
45.	Do you limit what you eat?	___	___
46.	Do you have any concerns you want to discuss with doctor?	___	___

Head **Elbow** **Upper Back** **Knee**
Neck **Forearm** **Lower Back** **Calf/Shin**
Shoulder **Hand/Fingers** **Hip** **Ankle**
Upper Arm **Chest** **Thigh** **Foot/Toes**

FEMALES

47. Have you ever had a menstrual period? ___ ___
48. How old were you when you have 1st menstrual period? _____
49. How many periods have you had in last 12 months? _____

Explain "Yes" answers here: _____
_____
_____
_____
_____
_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.
Signature of athlete _____ Date _____
Signature of parent/guardian _____Date_____