

Preparticipation Physical Evaluation

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) _____	Phone(W) _____

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

	Yes	No		Yes	No																
1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>																
2. Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>																
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>																
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>																
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>																
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>																
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>																
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>																
9. Has a doctor ever told you that you have (check all that apply):			32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>																
<input type="checkbox"/> High blood pressure		<input type="checkbox"/> A heart murmur	33. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>																
<input type="checkbox"/> High cholesterol		<input type="checkbox"/> A heart infection	34. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>																
10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>																
11. Has anyone in your family died of no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	36. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>																
12. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	37. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>																
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>																
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>																
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>																
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	41. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>																
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below:	<input type="checkbox"/>	<input type="checkbox"/>	42. Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>																
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	43. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>																
19. Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>																
<table border="1" style="font-size: small; border-collapse: collapse; width: 100%;"> <tr> <td style="padding: 2px;">Head</td> <td style="padding: 2px;">Neck</td> <td style="padding: 2px;">Shoulder</td> <td style="padding: 2px;">Upper Arm</td> <td style="padding: 2px;">Elbow</td> <td style="padding: 2px;">Forearm</td> <td style="padding: 2px;">Hand/ Fingers</td> <td style="padding: 2px;">Chest</td> </tr> <tr> <td style="padding: 2px;">Upper Back</td> <td style="padding: 2px;">Lower Back</td> <td style="padding: 2px;">Hip</td> <td style="padding: 2px;">Thigh</td> <td style="padding: 2px;">Knee</td> <td style="padding: 2px;">Calf/ Shin</td> <td style="padding: 2px;">Ankle</td> <td style="padding: 2px;">Foot/ Toes</td> </tr> </table>	Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest	Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes			45. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	46. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>																
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY																		
22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	47. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>																
23. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>	48. How old were you when you had your first menstrual period? _____																		
			49. How many periods have you had in the 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 _____ Signature of Parent/Guardian _____ Date _____