PRE-PARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Mark choice boxes like this ☉

Date of Exam ☐☐ / ☐☐ / ☐☐☐☐ (dd / mm / yyyy)

First Name

Last Name

Sex ☐ M ☐ F **Age** ☐☐ **Date of Birth** ☐☐ / ☐☐ / ☐☐☐☐ (dd / mm / yyyy)

Standard/ Form _____ **School** _____

Additional Sport(s) _____

Street Address

City/Town **Tel.** ☐☐☐ - ☐☐☐☐

Personal Physician

In case of emergency, contact:

Name

Relationship _____ **Tel.(H)** ☐☐☐ - ☐☐☐☐ **Cell** ☐☐☐ - ☐☐☐☐

Explain "Yes" answers in the space provided. Circle questions to which you do not know the answers.

	Yes	No	
1. Has a doctor ever denied or restricted your parcitipation in sports for any reason?	☐	☐	
2. Do you have an ongoing medical condition (e.g. diabetes or asthma)?	☐	☐	
3. Are you currently taking any prescription medicines or pills?	☐	☐	
4. Are you currently taking any non-prescription medicines or pills?	☐	☐	
5. Do you have allergies to medicines, pollens, foods or stinging insects?	☐	☐	
6. Have you ever passed out or nearly passed out DURING exercise?	☐	☐	
7. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐	
8. Have you ever had discomfort, pain or pressure in your chest during exercise?	☐	☐	
9. Does your heart race or skip beats during exercise?	☐	☐	
10. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection	☐	☐	
11. Has a doctor ever ordered a test for your heart (e.g. ECG, echocardiogram)?	☐	☐	
12. Has anyone in your family died for no apparent reason?	☐	☐	
13. Does anyone in your family have a heart problem?	☐	☐	
14. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐	
15.Does anyone in your family have Marfan syndrome?	☐	☐	
16.Have you ever spent the night in a hospital?	☐	☐	
17.Have you ever had surgery?	☐	☐	
18.Have you ever had an injury e.g. sprain, muscle or ligament tear or tendinitis that caused you to miss a practice or game? If yes, indicate the affected area.: ☐ 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 any broken or fractured bones or dislocated joints? If yes, indicate below. ☐ head ☐ neck ☐ shoulder ☐ upper arm ☐ elbow ☐ forearm ☐ hand/fingers ☐ chest ☐ upper back ☐ lower back ☐ hip ☐ thigh ☐ knee ☐ calf/shin ☐ ankle ☐ foot/toes	☐	☐	

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	Yes	No	
20. 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, indicate below.	☐	☐	
☐ head ☐ neck ☐ shoulder ☐ upper arm ☐ elbow ☐ forearm ☐ hand/fingers ☐ chest ☐ upper back ☐ lower back ☐ hip ☐ thigh ☐ knee ☐ calf/shin ☐ ankle ☐ foot/toes			
21. Have you ever had a stress fracture?	☐	☐	
22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐	
23. Do you regularly use a brace or assistive device?	☐	☐	
24. Has a doctor ever told you that you have asthma or allergies?	☐	☐	
25. Do you cough, wheeze or have diffculty breathing during or after exercise?	☐	☐	
26. Is there anyone in your family who has asthma?	☐	☐	
27. Have you ever used an inhaler or taken asthma medicine?	☐	☐	
28. Were you born without or are you missing a kidney, an eye, a testicle or any other organ?	☐	☐	
29. Have you had infectious mononucleosis (mono) within the last month?	☐	☐	
30. Do you have any rashes, pressure sores or other skin problems?	☐	☐	
31. Have you had a herpes skin infection?	☐	☐	
32. Have you ever had a head injury or concussion?	☐	☐	
33. Have you been hit in the head and been confused or lost your memory?	☐	☐	
34. Have you ever had a seizure?	☐	☐	
35. Do you have headaches with exercise?	☐	☐	
36. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?	☐	☐	
37. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐	
38. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐	
39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐	
40. Have you had any problems with your eyes or vision?	☐	☐	
41. Do you wear glasses or contact lenses?	☐	☐	
42. Do you wear protective eyewear such as goggles or a face shield?	☐	☐	
43. Are you happy with your weight?	☐	☐	
44. Are you trying to gain or lose weight?	☐	☐	
45. Has anyone recommended you change your weight or eating habits?	☐	☐	
46. Do you limit or carefully control what you eat?	☐	☐	
47. Do you have any concerns that you would like to discuss with a doctor?	☐	☐	

FEMALES ONLY

48. Have you ever had a menstrual period?	☐	☐	
49. How old were you when you had your first menstrual period?			☐☐
50. How many periods have you had in the last 12 months?			☐☐

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*

Date ☐☐ / ☐☐ / ☐☐☐☐

dd *mm* *yyyy*

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