

# 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.   -

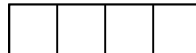
Personal Physician

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



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 difficulty 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

