

Preparticipation Physical Evaluation (History)

Date of Exam: _____

Name: _____ Sex: _____ Age: _____ Date of Birth: _____
 Grade: _____ School: _____ Sport(s): _____

Explain "Yes" answers below.

Circle questions you don't know the answers to.

Yes No

Yes No

1. Have you had a medical illness or injury since your last check up or sports physical? - -
2. Do you have an ongoing or chronic illness? - -
3. Have you ever had surgery or been hospitalized? - -
4. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? - -
5. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? - -
6. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? - -
7. Have you ever had a rash or hives develop during or after exercise? - -
8. Have you ever had dizziness, chest pain or passed out during or after exercise? - -
9. Do you get tired more quickly than your friends do during exercise? - -
10. Have you ever had racing of your heart, skipped heartbeats, high blood pressure, high cholesterol or a heart murmur? - -
11. Has any family member or relative died of heart problems or of sudden death before age 50? - -
12. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? - -
13. Has a physician ever denied or restricted your participation in sports for any heart problems? - -
14. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? - -
15. Have you ever had a concussion, been knocked out or lost your memory? - -
16. Have you ever had a seizure? - -
17. Do you have frequent or severe headaches? - -
18. Have you ever had numbness or tingling in your arms, hands, legs or feet? - -
19. Have you ever had a stinger, burner or pinched nerve? - -
20. Have you ever become ill from exercising in the heat? - -
21. Do you cough, wheeze, or have trouble breathing during or after activity? - -
22. Do you have asthma? - -
23. Do you have seasonal allergies that require medical treatment? - -

24. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? - -
25. Do you wear glasses, contacts or protective eyewear or have eye/vision problems? - -
26. Have you ever had any sprains, fractures, joint pain or swelling? - -

If yes, check appropriate box and explain below

- | | | |
|-------------|-----------|-------------|
| _ Head | _ Elbow | _ Hip |
| _ Neck | _ Forearm | _ Thigh |
| _ Back | _ Wrist | _ Knee |
| _ Chest | _ Hand | _ Shin/calf |
| _ Shoulder | _ Finger | _ Ankle |
| _ Upper arm | | _ Foot |

27. Do you want to weigh more or less than you do now? - -
28. Do you lose weight regularly to meet weight requirements for your sport? - -
29. Do you feel stressed out? - -

FEMALES ONLY

30. When was your first menstrual period? _____
31. When was your most recent menstrual period? _____
32. How much time do you usually have from the start of one period to the start of another? _____
33. How many periods have you had in the last year? _____
34. What was the longest time between periods in the last year? _____

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 _____