

**Preparticipation Physical Examination**

**HISTORY**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Exam \_\_\_\_\_  
 Grade \_\_\_\_\_ School (Upcoming Year) \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 Personal Physician \_\_\_\_\_ Physicians Phone \_\_\_\_\_  
*In case of emergency, contact:*  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

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

	YES	NO		YES	NO
1. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	10. 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 or hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had a sprain, strain or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Head	Elbow	Thigh
Have you had high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	Neck	Forearm	Knee
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	Back	Wrist	Shin/ calf
Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	Chest	Hand	Ankle
Have you ever had any conditions involving your heart?	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder	Finger	Foot
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	Upper arm	Hip	
2. Have you had a medical illness or injury since your last checkup or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, check appropriate box and explain below.</i>		
3. Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
*4. Are you currently taking any prescription or nonprescription (over the counter) medications or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	15. Record dates of your most recent immunizations (shots) for:	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any allergies (for example, to pollen, medicines, food or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____ MMR _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____ Chickenpox _____	<input type="checkbox"/>	<input type="checkbox"/>
*7. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Females Only</b>		
How many? # _____			16. Are you having irregular periods?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out, become unconscious or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	Explain "Yes" answers here: _____		
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>			
*8. Have you ever become ill from exercises in the heat?	<input type="checkbox"/>	<input type="checkbox"/>			
9. Do you cough, wheeze or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>			

I understand and give permission for my son/ daughter to have a FREE Screening Sports Physical with an EKG and ECHO (if necessary).

Signature of Parent/Guardian/ Student if over 18 \_\_\_\_\_

Date \_\_\_\_\_ School (Upcoming year) \_\_\_\_\_