Pre-participation Physical Evaluation

PHYSICAL HISTORY FORM

Full Legal Name: _____ **Date of Birth**: _____

School: _____ Grade:_____ Age:_____ Gender Identity: ❑Female ❑Male

MEDICINES AND ALLERGIES		
Please list all prescription, including birth control, over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking on a regular basis. _____ _____ Do you have any allergies? ❑No ❑Yes If yes, please identify: ❑Medicines ❑Pollens ❑Food ❑Stinging Insects		
Circle questions you don't know the answers to.		
HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50?		
Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?		
Have you had unexplained fainting or unexplained seizures?		
HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
Has a doctor ever denied or restricted your participation in sports for any reason?		
Do you have any ongoing medical conditions? If so, please identify: ❑Asthma ❑Anemia ❑Diabetes ❑Infections ❑Life-Threatening Allergies ❑Other:_____		
Have you ever had surgery?		
Have you ever passed out or nearly passed out DURING or AFTER exercise?		
Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?		
Does your heart ever race or skip beats (irregular beats) during exercise?		
Has a doctor ever told you that you have (check all that apply): ❑High blood pressure ❑A heart murmur ❑High cholesterol ❑A heart infection ❑Kawasaki disease ❑Other: _____		
Have you ever had an unexplained seizure or a seizure disorder?		
Do you cough, wheeze or have difficulty breathing during or after exercise?		
Were you born without or are you missing a kidney, an eye, a testicle, your spleen or any other organ?		
Do you or anyone in your family have asthma?		
Do you have headaches with exercise?		
Do you have groin pain or a painful bulge or hernia in the groin area?		
Have you had infectious mononucleosis (mono) within the last month?		
Do you have any rashes, pressure sores or other skin problems?		
Have you ever had a head injury or concussion?		
Have you ever had a hit or blow to the head that caused confusion, prolonged headache or memory problems?		
Have you ever been unable to move your arms or legs after being hit or falling?		
Have you had any eye injuries or do you wear glasses or contacts?		
Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?		
Are you on a special diet or do you avoid certain types of foods?		
Have you ever become ill while exercising in the heat?		
Do you have any menstrual problems?		
Do you get frequent muscle cramps when exercising?		
Have you ever been tested for or have anemia?		
Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or a game?		
Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches?		
Have you ever been told that you have or have neck instability or atlantoaxial instability? (Down Syndrome or Dwarfism)		
Do you regularly use a brace, orthotics or other assistive device?		
Do you have a bone, muscle or joint injury that bothers you?		
Do any of your joints become painful, swollen, feel warm or look red?		
Do you have any history of juvenile arthritis or connective tissue disease?		
Explain "yes" answers here and/or on the back of this form. _____ _____		

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student Athlete:_____ Date: _____

Signature of Parent/Guardian:_____ Date: _____