Pre-participation Physical Evaluation

History

Date ________

Name ____________________ Sex ______ Age ______ Date of birth ________

Grade ______ Sport ____________ ____________ ____________

Personal physician ____________ ____________ ____________

Address Physician's Phone

Insurance Carrier ____________ **Policy #** ____________

Explain "Yes answers below:

		Yes	No
1.	Have you ever been hospitalized?	[ ]	[ ]
	Have you ever had surgery?	[ ]	[ ]
2.	Are you presently taking any medications or pills?	[ ]	[ ]
3.	Do you have any allergies (medicine, bees or other stinging insects)?	[ ]	[ ]
4.	Have you ever passed out during or after exercise?	[ ]	[ ]
	Have you ever been dizzy during or after exercise?	[ ]	[ ]
	Have you ever had chest pain during or after exercise?	[ ]	[ ]
	Do you tire more quickly than your friends during exercise?	[ ]	[ ]
	Have you ever had high blood pressure?	[ ]	[ ]
	Have you ever been told that you have a heart murmur?	[ ]	[ ]
	Have you ever had racing of your heart or skipped heartbeats?	[ ]	[ ]
	Has anyone in you family died of heart problems or a sudden death before age 50?	[ ]	[ ]
5.	Do you have any skin problems (itching, rashes, acne)?	[ ]	[ ]
6.	Have you ever had a head injury?	[ ]	[ ]
	Have you ever been knocked out or unconscious?	[ ]	[ ]
	Have you ever had a seizure?	[ ]	[ ]
	Have you ever had a stinger, burner or pinched nerve?	[ ]	[ ]
7.	Have you ever had heat or muscle cramps?	[ ]	[ ]
	Have you ever been dizzy or passed out in the heat?	[ ]	[ ]
8.	Do you have trouble breathing or do you cough during or after activity?	[ ]	[ ]
9.	Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc)?	[ ]	[ ]
10.	Have you had any problems with your eyes or vision?	[ ]	[ ]
	Do you wear glasses or contacts or protective eye wear?	[ ]	[ ]
11.	Have you ever sprained/strained, dislocated, fractured, broken, or had repeated swelling or other injuries of any bones or joints?	[ ]	[ ]

[ ] Head [ ] Shoulder [ ] Thigh [ ] Neck [ ] Elbow [ ] Knee [ ] Chest

[ ] Forearm [ ] Shin/calf [ ] Back [ ] Wrist [ ] Ankle [ ] Hip [ ] Hand [ ] Foot

		Yes	No
12.	Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?	[ ]	[ ]
13.	Have you had a medical problem or injury since your last evaluation?	[ ]	[ ]

14. When was your last tetanus shot? ____________

    When was your last measles immunization? ____________

15. When was your first menstrual period? ____________

    When was your last menstrual period? ____________

    What was the longest time between your periods last year? ____________

    Explain "Yes" answers:

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

Date ________

Signature of athlete ____________

Signature of parent/guardian ____________