Preparticipation Physical Evaluation—History Form

This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.

Date of Exam: _____ Name: _____

Date of Birth: _____ Sex: _____ Age: _____

Grade: _____ School: _____

Sport(s): _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you're currently taking:

_____

Do you have allergies? ☐ Yes ☐ No If yes, please identify specific allergy below:

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insect

Explain "Yes" answers below. Circle questions you don't know the answers to.

General Questions		Medical Questions	
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐ Yes ☐ No	26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐ Yes ☐ No
2. Do you have any ongoing medical conditions? If yes, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____	☐ Yes ☐ No	27. Have you ever used an inhaler or taken asthma medicine?	☐ Yes ☐ No
3. Have you ever spent the night in the hospital?	☐ Yes ☐ No	28. Is there anyone in your family who has asthma?	☐ Yes ☐ No
4. Have you ever had surgery?	☐ Yes ☐ No	29. Were you born without or are you missing a kidney, an eye, a testicle (male), your spleen, or any other organ?	☐ Yes ☐ No
Heart Health Questions About You		30. Do you have groin pain or a painful bulge or hernia in the groin area?	☐ Yes ☐ No
5. Have you ever passed our or nearly passed out DURING or AFTER exercise?	☐ Yes ☐ No	31. Have you had infectious mononucleosis (mono) within the last month?	☐ Yes ☐ No
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	☐ Yes ☐ No	32. Do you have any rashes, pressure sores, or other skin problems?	☐ Yes ☐ No
7. Does your heart ever race or skip beats (irregular beats) during exercise?	☐ Yes ☐ No	33. Have you had a herpes of MRSA skin infection?	☐ Yes ☐ No
8. Has a doctor ever told you that you have any heart problems? If yes, check all that apply:	☐ Yes ☐ No	34. Have you ever had a head injury or concussion?	☐ Yes ☐ No

Patient Name: _____ DOB:_____

☐ High Blood Pressure ☐ A Heart Murmur ☐ High Cholesterol ☐ A Heart Infection ☐ Kawasaki Disease Other:			
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)	☐ Yes ☐ No	35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?	☐ Yes ☐ No
10. Do you get lightheaded or feel more short of breath than expected during exercise?	☐ Yes ☐ No	36. Do you have a history of seizure disorder?	☐ Yes ☐ No
11. Have you ever had an unexplained seizure?	☐ Yes ☐ No	37. Do you have headaches with exercise?	☐ Yes ☐ No
12. Do you get more tired or short of breath more quickly than your friends during exercise?	☐ Yes ☐ No	38. Have you ever had numbness, tingling, or weakness in your arms of legs after being hit or falling?	☐ Yes ☐ No
Heart Health Questions About Your Family		39. Have you ever been unable to move your arms or legs after being hit or falling?	☐ Yes ☐ No
13. Has any family member or relative died of hear problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?	☐ Yes ☐ No	40. Have you ever become ill while exercising in the heat?	☐ Yes ☐ No
14. Dies anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?	☐ Yes ☐ No	41. Do you get frequent cramps when exercising?	☐ Yes ☐ No
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	☐ Yes ☐ No	42. Do you or someone in your family have sickle cell trait or disease?	☐ Yes ☐ No
16. Has anyone in your family had unexplained fainting, unexplained seizures, ornear drowning?	☐ Yes ☐ No	43. Have you had any problems with your eyes or vision?	☐ Yes ☐ No
Bone and Joint Questions		44. Have you had any eye injuries?	☐ Yes ☐ No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?	☐ Yes ☐ No	45. Do you wear glasses or contact lenses?	☐ Yes ☐ No
18. Have you ever had any broken or fractured bones or dislocated joints?	☐ Yes ☐ No	46. Do you wear protective eyewear, such as goggles or a face shield?	☐ Yes ☐ No
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?	☐ Yes ☐ No	47. Do you worry about your weight?	☐ Yes ☐ No
20. Have you ever had a stress fracture?	☐ Yes	48. Are you trying to or has anyone told	☐ Yes

Patient Name: _____ DOB:_____

	☐ No	recommended that you gain or lose weight?	☐ No
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)	☐ Yes ☐ No	49. Are you on a special diet or do you avoid certain types of foods?	☐ Yes ☐ No
22. Do you regularly use a brace, orthotics, or other assistive device?	☐ Yes ☐ No	50. Have you ever had an eating disorder?	☐ Yes ☐ No
23. Do you have a bone, muscle, or joint injury that bothers you?	☐ Yes ☐ No	51. Do you have any concerns that you would like to discuss with a doctor?	☐ Yes ☐ No
24. Do any of your joints become painful, swollen, feel warm, or look red?	☐ Yes ☐ No	**Females Only**	
25. Do you have any history of juvenile arthritis or connective tissue disease?	☐ Yes ☐ No	52. Have you ever had a menstrual period?	☐ Yes ☐ No
Explain Yes Answers:		53. How old were you when you had your first menstrual period?	
		54. 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/Guardian Date

Patient Name: _____ DOB:_____