



PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: The student and parent must fill out this form prior to seeing the provider. The provider should keep this form in the chart.)

NAME: _____

Date of Birth _____

Sex _____

Age _____

Grade _____

School _____

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

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Do you have any allergies? Yes _____ No _____

If yes, please identify specific allergy below.

Do you currently use an EpiPen? Yes _____ No _____

_____ Medicines _____ Pollen _____ Food _____ Stinging Insects

Explain "Yes" answers below. *Please circle questions you do not know the answers to.*

YES NO

GENERAL QUESTIONS	YES	NO			
1. Has a doctor ever denied or restricted your participation in sports for any reason?				27. Do you have groin pain or a painful bulge or hernia in the groin area?	
2. Do you have any ongoing medical conditions? If so, please identify Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Infections <input type="checkbox"/> Diabetes <input type="checkbox"/>				28. Do you have any rashes, pressure sores, or other skin problems?	
3. Have you ever spent the night in the hospital?				29. Have you ever had a head injury or concussion(s)? If yes, please provide date(s): _____, _____, _____.	
4. Have you ever had surgery?				30. Do you have a history of seizure disorder?	
HEART HEALTH QUESTIONS ABOUT YOU	YES	NO		31. Have you had a herpes or MRSA skin infection?	
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?				32. Do you have headaches with exercise?	
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?				33. Have you ever had numbness, tingling, or weakness in your arms, or legs after being hit or falling?	
7. Does your heart ever race or skip beats (irregular beats) during exercise?				34. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?	
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High BP <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Infection <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kawasaki Disease				35. Have you ever been unable to move your arms or legs after being hit or falling?	
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)				36. Have you ever become ill while exercising in the heat?	
10. Do you get lightheaded or feel more short of breath than expected during exercise?				37. Do you get frequent muscle cramps when exercising?	
11. Have you ever had an unexplained seizure?				38. Have you had any problems with your eyes or vision?	
12. Do you get more tired or short of breath more quickly than your friends during exercise?				39. Have you had any eye injuries?	
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	YES	NO		40. Do you wear glasses or contact lenses?	
13. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?				41. Do you wear protective eyewear, such as goggles or a face shield?	
14. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?				42. Are you trying or has anyone recommended that you gain or lose weight?	
15. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?				43. Are you on a special diet or do you avoid certain types of foods?	
BONE AND JOINT QUESTIONS	YES	NO		44. Have you ever had an eating disorder?	
16. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?				45. Do you have any concerns that you would like to discuss with a doctor?	
17. Have you ever had any broken or fractured or dislocated joints?				46. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	
18. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?					
19. Have you ever had a stress fracture?					
20. Do you regularly use a brace, orthotics, or other assistive device?					
21. Do you have a bone, muscle, or joint injury that bothers you?					
22. Do any of your joints become painful, swollen, feel warm, or look red?					
MEDICAL QUESTIONS	YES	NO			
23. Do you cough, wheeze, or have difficulty breathing during or after exercises?					
24. Have you ever used an inhaler or taken asthma medicine?					
25. Is there anyone in your family who has asthma?					
26. Do you currently use an asthma Rescue inhaler?					
				FEMALES ONLY	YES NO
				47. Have you ever had a menstrual period?	
				48. How old were you when you had your first menstrual period?	
				49. How many periods have you had in the last 12 months?	
				Explain "yes" answers here:	

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

Revised 6/2017

Signature of Athlete _____ Date: _____

Signature of Parent/Guardian _____ Date: _____