

Preparticipation Physical Evaluation - History Form

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of Birth: _____ Sex: _____

Date of Examination: _____ Sport(s): _____

List past and current medical conditions: _____

 Have you ever had surgery? If yes, list all past surgical procedures: _____

 Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional): _____

 Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects): _____

General Questions. Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.			Yes	No	Medical Questions			Yes	No
1. Do you have any concerns that you would like to discuss with your provider?					16. Do you cough, wheeze, or have difficulty breathing during or after exercise?				
2. Has a provider ever denied or restricted your participation in sports for any reason?					17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?				
3. Do you have any ongoing medical issues or recent illness?					18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?				
Heart Health Questions About You				Yes	No	19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?			
4. Have you ever passed out or nearly passed out DURING or AFTER exercise?					20. Have you ever had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?				
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?					21. Have you ever had numbness, tingling, or weakness in your arms or leg, or been unable to move your arms or legs after being hit or falling?				
6. Does your heart ever race, flutter in your chest or skip beats (irregular beats) during exercise?					22. Have you ever become ill while exercising in the heat?				
7. Has a doctor ever told you that you have any heart problems?					23. Do you or someone in your family have sickle cell trait or disease?				
8. Has a doctor ever ordered a test for your heart? (for example Electrocardiography (ECG) or echocardiography.					24. Have you ever had or do you have any problems with your eyes or vision?				
9. Do you get lightheaded or feel shorter of breath than your friends during exercise?					25. Do you worry about your weight?				
10. Have you ever had a seizure?					26. Are you trying to or has anyone recommended that you gain or lose weight?				
Health Questions About Your Family				Yes	No	27. Are you on a special Diet or do you avoid certain types of foods?			
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including drowning or unexplained car accident)?					28. Have you ever had an eating disorder?				
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTs), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?					Females Only			Yes	No
13. Does anyone in your family had a pacemaker or implanted Defibrillator before age 35?					29. Have you ever had a menstrual period?				
Bone and Joint Questions				Yes	No	30. How old were you when you had your first menstrual period?			
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon that caused you to miss a game or practice?					31. When was your most recent menstrual period?				
15. Do you have a bone, muscle, ligament or joint injury that bothers you?					32. How many periods have you had in the past 12 months?				

Explain a "Yes" answer here: _____

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date _____

Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

Name (please print) _____

As a parent or legal guardian of the above named student-athlete. I give permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

Signature of Athlete _____ Date: _____

Signature of Parent/Guardian _____ Date: _____