Pre-participation Physical Evaluation

PHYSICAL HISTORY FORM

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

School: _____ Grade:_____ Age:_____ Gender Identity: ☐Female ☐Male ☐**X**

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