Pre-Participation Physical Evaluation

This form is to be filled out and signed by the patient and parent/guardian prior to seeing a physician.

Name _____ Date of Exam _____

Date of Birth _____/_____/_____ Sex __M__F__ Grade _____

Sport(s) _____

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

_____

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medicine(s) Pollen(s) Food Stinging Insects

Other _____

Please indicate yes (Y) or no (N) to the following. Explain each "yes" answer on the next page.

1) Has a doctor ever denied or restricted your participation in sports for any reason? Y N

2) Do you have any ongoing medical conditions? If yes, please identify below. Y N

Asthma Anemia Diabetes Infections Other: _____

3) Have you ever spent the night in the hospital? Y N

4) Have you ever had surgery? Y N

Heart Health Question About You

5) Have you ever passed out or nearly passed out DURING or AFTER exercise? Y N

6) Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? Y N

7) Does your heart ever race or skip beats (irregular beats) during exercise? Y N

8) Has a doctor ever told you that you have any heart problems? If so, circle all that apply. Y N

High blood pressure Heart murmur High cholesterol

Heart infection Kawasaki disease Other: _____

9) Has a doctor ever ordered a test for your heart? (Ex ECG/EKG, echocardiogram) Y N

10) Do you get lightheaded or feel more short of breath than expected during exercise? Y N

11) Have you ever had an unexplained seizure? Y N

12) Do you get more tired or short of breath more quickly than your friends during exercise? Y N

Heart Health Questions About Your Family

13) Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? Y N

14) Does 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? Y N

15) Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? Y N

16) Has anyone in your family had unexplained fainting, unexpected seizures, or near drowning? Y N

Bone and Joint Questions

17) Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?	Y	N
18) Have you ever had any broken or fractured bones or dislocated joints?	Y	N
19) Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?	Y	N
20) Have you ever had a stress fracture?		
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)	Y	N
22) Do you regularly use a brace, orthotics, or other assistive device?	Y	N
23) Do you have a bone, muscle, or joint injury that bothers you?	Y	N
24) Do any of your joints become painful, swollen, feel ward, or look red?	Y	N
25) Do you have any history of juvenile arthritis or connective tissue disease?	Y	N

Medical Questions

26) Do you cough, wheeze, or have difficulty breathing during or after exercise?	Y	N
27) Have you ever used an inhaler or taken asthma medicine?	Y	N
28) Is there anyone in your family who has asthma?	Y	N
29) Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	Y	N
30) Do you have groin pain or a painful bulge or hernia in the groin area?	Y	N
31) Have you had infectious mononucleosis (mono) within the last month?	Y	N
32) Do you have any rashes, pressure sores, or other skin problems?	Y	N
33) Have you had a herpes or MRSA skin infection?	Y	N
34) Have you ever had a head injury or concussion?	Y	N
35) Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?	Y	N
36) Do you have a history of seizure disorder?	Y	N
37) Do you have headaches with exercise?	Y	N
38) Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	Y	N
39) Have you ever been unable to move your arms or legs after being hit or falling?	Y	N
40) Have you ever become ill while exercising in the heat?	Y	N
41) Do you get frequent muscle cramps when exercising?	Y	N
42) Do you or someone in your family have sickle cell trait or disease?	Y	N
43) Have you had any problems with your eyes or vision?	Y	N
44) Have you had any eye injuries?	Y	N
45) Do you wear glasses or contact lenses?	Y	N
46) Do you wear protective eyewear, such as goggles or a face shield?	Y	N
47) Do you worry about your weight?	Y	N
48) Are you trying to or has anyone recommended that you gain or lose weight?	Y	N

49) Are you on a special diet, or do you avoid certain types of foods? Y N

50) Have you ever had an eating disorder? Y N

51) Do you have any concerns that you would like to discuss with a doctor? Y N

Females Only

52) Have you ever had a menstrual period? Y N

53) How old were you when you had your first menstrual period? _____

54) How many periods have you had in the last 12 months? _____

Explain each "yes" answer here.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

Athlete Signature _____ Date _____

Parent/Guardian Signature _____ Date _____