■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

(Note: 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					
Nam				Date of birth		
Sex	Age Grade Sch	ool		Sport(s)		
Me	dicines and Allergies: Please list all of the prescription and over	-the-co	unter m	nedicines and supplements (herbal and nutritional) that you are currently	taking	
	you have any allergies?	ntify spe	ecific al	llergy below. □ Food □ Stinging Insects		
Expl	in "Yes" answers below. Circle questions you don't know the an	swers t	ю.			
	ERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2.	Do you have any ongoing medical conditions? If so, please identify			27. Have you ever used an inhaler or taken asthma medicine?		
	below: Asthma Anemia Diabetes Infections			28. Is there anyone in your family who has asthma?		
3	Other: Have you ever spent the night in the hospital?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
_	Have you ever had surgery?			30. Do you have groin pain or a painful bulge or hernia in the groin area?	1	
_	RT HEALTH QUESTIONS ABOUT YOU	Yes	No	31. Have you had infectious mononucleosis (mono) within the last month?		
	Have you ever passed out or nearly passed out DURING or			32. Do you have any rashes, pressure sores, or other skin problems?		
_	AFTER exercise? Have you ever had discomfort, pain, tightness, or pressure in your			33. Have you had a herpes or MRSA skin infection?		
0.	chest during exercise?			34. Have you ever had a head injury or concussion?		-
7.	Does your heart ever race or skip beats (irregular beats) during exercise?			35. 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:			36. Do you have a history of seizure disorder?		
	☐ High blood pressure ☐ A heart murmur			37. Do you have headaches with exercise?		
	☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other:			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
	Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			39. Have you ever been unable to move your arms or legs after being hit or falling?		
10.	Do you get lightheaded or feel more short of breath than expected during exercise?			40. Have you ever become ill while exercising in the heat? 41. Do you get frequent muscle cramps when exercising?	-	-
11.	Have you ever had an unexplained seizure?			42. Do you or someone in your family have sickle cell trait or disease?	+	
12.	Do you get more tired or short of breath more quickly than your friends			43. Have you had any problems with your eyes or vision?	1	
during exercise?				44. Have you had any eye injuries?		
	RT HEALTH QUESTIONS ABOUT YOUR FAMILY Has any family member or relative died of heart problems or had an	Yes	No	45. Do you wear glasses or contact lenses?		
unexpected or unexplained sudden death before age 50 (including				46. Do you wear protective eyewear, such as goggles or a face shield?	₩	├
-14	drowning, unexplained car accident, or sudden infant death syndrome)?			47. Do you worry about your weight? 48. Are you trying to or has anyone recommended that you gain or	+	-
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?			49. Are you on a special diet or do you avoid certain types of foods?	-	
				50. Have you ever had an eating disorder?	+	t
15.	Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			51. Do you have any concerns that you would like to discuss with a doctor?		
16.	Has anyone in your family had unexplained fainting, unexplained			FEMALES ONLY		
_	seizures, or near drowning?			52. Have you ever had a menstrual period?	₩	
	E AND JOINT QUESTIONS	Yes	No	53. How old were you when you had your first menstrual period? 54. How many periods have you had in the last 12 months?	-	
17.	Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			Explain "yes" answers here		
18.	Have you ever had any broken or fractured bones or dislocated joints?			- LAPIAIII yes allowers here		
19.	Have you ever had an injury that required x-rays, MRI, CT scan, njections, therapy, a brace, a cast, or crutches?					
-	Have you ever had a stress fracture?					
	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)					
_	Do you regularly use a brace, orthotics, or other assistive device?					
	Do you have a bone, muscle, or joint injury that bothers you? Do any of your joints become painful, swollen, feel warm, or look red?		-			
-	Do you have any history of juvenile arthritis or connective tissue disease?					
	eby state that, to the best of my knowledge, my answers to	the abo	ve que	estions are complete and correct.		
Signa	ure of athlete Signature o	f parent/g	uardian _	Date		
				llege of Sports Medicine, American Medical Society for Sports Medicine, American is granted to reprint for noncommercial, educational purposes with acknowledgm	nent.	9-2681/04

eFigure A. Preparticipation evaluation history form.

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