

# Preparticipation Physical Examination Questionnaire

## HEALTH HISTORY

Name \_\_\_\_\_ Sex M / F Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

\_\_\_\_\_ School Sports \_\_\_\_\_ (Fall) \_\_\_\_\_ (Winter) \_\_\_\_\_ (Spring)

**IN CASE OF EMERGENCY, CONTACT:** Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 (Parent Information)

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_ Beeper \_\_\_\_\_

Personal Physician's Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

- |  | YES                      | NO                       |  |                                  |                                    |
|--|--------------------------|--------------------------|--|----------------------------------|------------------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical?   | <input type="checkbox"/> | <input type="checkbox"/> | 30. Have you ever had any problem with your eyes or vision?  | <input type="checkbox"/>         | <input type="checkbox"/>           |
| 2. Have you ever been hospitalized overnight?  | <input type="checkbox"/> | <input type="checkbox"/> | 31. Have you ever had dental health problems?  | <input type="checkbox"/>         | <input type="checkbox"/>           |
| 3. Have you ever had surgery?  | <input type="checkbox"/> | <input type="checkbox"/> | 32. Have you broken or fractured any bones or dislocated any joints, or been diagnosed with a stress fracture?   | <input type="checkbox"/>         | <input type="checkbox"/>           |
| 4. Are you currently taking any prescription or nonprescription (over the counter) medications or pills or using an inhaler?   | <input type="checkbox"/> | <input type="checkbox"/> | 33. Have you ever had a sprain, strain, or swelling after injury or any other problems with pain or swelling in muscles, tendons, bones, or joints that has kept you from participating in sports? | <input type="checkbox"/>         | <input type="checkbox"/>           |
| 5. Have you ever taken any supplements or vitamins to help you improve your performance?   | <input type="checkbox"/> | <input type="checkbox"/> | <i>If yes, check appropriate box and explain below.</i>  |                                  |                                    |
| 6. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Head  | <input type="checkbox"/> Elbow   | <input type="checkbox"/> Hip       |
| 7. Have you ever had a rash or hives develop during or after exercise?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Neck  | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh     |
| 8. Have you ever been dizzy or passed out during or after exercise?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Back  | <input type="checkbox"/> Wrist   | <input type="checkbox"/> Knee      |
| 9. Have you ever had chest pain during or after exercise?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Chest   | <input type="checkbox"/> Hand    | <input type="checkbox"/> Shin/Calf |
| 10. Have you ever had high blood sugar (diabetes)?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Shoulder  | <input type="checkbox"/> Finger  | <input type="checkbox"/> Ankle     |
| 11. Have you ever been diagnosed with anemia?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Upper Arm   | <input type="checkbox"/> Foot    |                                    |
| 12. Have you ever had racing of your heart or skipped heartbeats?  | <input type="checkbox"/> | <input type="checkbox"/> | <b>FEMALES ONLY</b>  |                                  |                                    |
| 13. Have you had high blood pressure?  | <input type="checkbox"/> | <input type="checkbox"/> | 34. Has there been a recent change in menstrual patterns?  | <input type="checkbox"/>         | <input type="checkbox"/>           |
| 14. Have you ever been told you have a heart murmur?   | <input type="checkbox"/> | <input type="checkbox"/> | 35. At what age did you experience your first menstrual period?  | _____                            |                                    |
| 15. Has any family member or relative died of heart problems or of sudden death before age 50?   | <input type="checkbox"/> | <input type="checkbox"/> | 36. When was your most recent menstrual period? ___/___/___  | _____                            |                                    |
| 16. Have you had a severe viral infection?   | <input type="checkbox"/> | <input type="checkbox"/> | 37. How much time do you usually have from the start of one period to the start of another? _____  | _____                            |                                    |
| 17. Has a physician ever denied or restricted your participation in sports for any heart problems?   | <input type="checkbox"/> | <input type="checkbox"/> | 38. How many periods have you had in the last year? _____  | _____                            |                                    |
| 18. Have you ever been diagnosed with blood or bleeding disorders?   | <input type="checkbox"/> | <input type="checkbox"/> | 39. What was the longest time between periods in the last year?  | _____                            |                                    |
| 19. Have you ever had a kidney or bladder problem (absence of a paired organ)?   | <input type="checkbox"/> | <input type="checkbox"/> | <p style="margin: 0;"><b>Explain "Yes" Answers Here (Identify each answer with question number)</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> |                                  |                                    |
| 20. Have you ever had a head injury or concussion?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                                  |                                    |
| 21. Have you ever been knocked out, become unconscious, or lost your memory?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                                  |                                    |
| 22. Have you ever had a seizure or convulsion?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                                  |                                    |
| 23. Do you have frequent or severe headaches?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                                  |                                    |
| 24. Do you cough, wheeze, or have trouble breathing during or after activity that prevents you from playing?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                                  |                                    |
| 25. Do you have asthma or lung disease?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                                  |                                    |
| 26. Do you have seasonal allergies that require medical treatment?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                                  |                                    |
| 27. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, foot orthotics, retainer on your teeth, hearing aid)? | <input type="checkbox"/> | <input type="checkbox"/> |  |                                  |                                    |
| 28. Have you ever had any problem with your ears or hearing?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                                  |                                    |
| 29. Do you tire more easily than you feel you should?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                                  |                                    |

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

Signature of Athlete \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_ DATE \_\_\_\_\_