

## PRE-PARTICIPATION PHYSICAL HISTORY FORM

This MEDICAL HISTORY FORM must be completed annually by parent (or guardian) and student. These questions are designed to determine risk of acquired conditions or history that would make it hazardous to participate in athletic activity.

Name: \_\_\_\_\_ M / F DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

School: \_\_\_\_\_ Sports: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Explain "Yes" answers below. **Circle** the questions you don't know the answer to.

- |  |   |   |
|--|---|---|
| 1. Has a doctor ever denied or restricted your participation in sports?  | Y | N |
| 2. Do you have an ongoing medical condition (like asthma or diabetes, etc.)?   | Y | N |
| 3. Are you currently taking any prescription or over the counter medications?  | Y | N |
| 4. Do you have any allergies to medications, foods, pollens or insects?  | Y | N |
| 5. Have you ever passed out during or after exercise?  | Y | N |
| Have you ever been dizzy during or after exercise?   | Y | N |
| Have you ever had chest pain during or after exercise?   | Y | N |
| 6. Has a doctor ever told you that you have a heart murmur, high blood pressure, high cholesterol, or a heart infection? | Y | N |
| Has any family relative died of heart problems or of sudden death before 50?   | Y | N |
| Do you have family history of Marfan's syndrome, cardiomyopathy, long QT syndrome or abnormal heart rhythm?              | Y | N |
| 6. Have you ever had a head injury or a concussion?  | Y | N |
| 7. Do you have asthma?   | Y | N |
| Do you cough, wheeze or have difficulty breathing during or after exercise?  | Y | N |
| 8. Have you ever become ill from exercising in the heat?   | Y | N |
| 9. Are you missing any paired organ?   | Y | N |
| 10. Do you use any special protective equipment (i.e. brace or assistive device)?  | Y | N |
| 11. Do you wear glasses on contacts?   | Y | N |
| 12. Have you ever had surgery?   | Y | N |
| 13. Have you ever had a sprain, strain or swelling after injury?   | Y | N |
| Have you dislocated any joints or broken any bones?  | Y | N |
| Have you had any other problems with muscles, tendons, joints, etc. (circle below)                                       | Y | N |
| Head Neck Shoulder Arm/Elbow Wrist Hand Chest  |   |   |
| Back Hip Leg Knee Ankle Foot Other: _____  |   |   |
| 14. Are you trying to lose or gain weight?   | Y | N |
| Have you lost weight recently?   | Y | N |
| 15. Have you had a significant illness in the last month (i.e. mono or pneumonia)?                                       | Y | N |

**FEMALES ONLY:**

16. At what age did you begin menstruation? \_\_\_\_\_  
 How many periods have you had this year? \_\_\_\_\_  
 Do you experience disturbance of your menstruation with exercise? Y N

EXPLANATIONS: \_\_\_\_\_  
 \_\_\_\_\_

*\*\*\* If, between the date of this evaluation and the beginning of athletic participation, any illness or injury should occur that may impact the performance or safety of this athletes participation, we will notify our primary care physician and/or coach.*

To the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete \_\_\_\_\_ Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_