

Preparticipation Physical Evaluation

*******Parents please assist your student in filling out this form regarding your student's medical history, and sign at the bottom of the second page. Take this completed form to the physical so that they may review it prior to the exam.**

Name _____ Sex M F Date of Birth ____/____/____

Grade _____ Age _____ Sport(s) _____

Address _____ Phone _____

Personal Physician _____ Phone _____

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Please circle yes or no. EXPLAIN YES ANSWERS ON SECOND PAGE.

1. Have you had a medical illness or injury since your last check up or sports physical? Yes No
Do you have any ongoing or chronic illness? Yes No
2. Have you ever been hospitalized overnight? Yes No
Have you ever had surgery? Yes No
3. Are you currently taking any prescription or over the counter medications or pill or using an inhaler? Yes No
Have you ever take any supplements or vitamins to help you gain or lose weight or improve performance? Yes No
4. Do you have any allergies(ie: pollen, medicine, food, stinging insects)? Yes No
5. Have you ever passed out during or after exercise? Yes No
Have you ever been dizzy during or after exercise? Yes No
Have you ever had chest pain during or after exercise? Yes No
Have you ever had racing of your heart or skipped heartbeats? Yes No
Have you had high blood pressure or high cholesterol? Yes No
Have you ever been told you have a heart murmur? Yes No
Has any family member or relative died of heart problems or sudden death before age 50? Yes No
Have you had a severe viral infection(ie: myocarditis or mononucleosis) within the last month? Yes No
Has a physician ever denied or restricted your participation in sports for any heart problems? Yes No
6. Have you ever had a head injury or concussion? Yes No
Have you ever been knocked out, become unconscious, or lost your memory? Yes No
Have you ever had a seizure? Yes No
Do you have frequent headaches? Yes No
Have you ever had numbness or tingling in arms, hand, leg, or feet? Yes No
Have you ever had a stinger, burner, or pinched nerve? Yes No
7. Have you ever become ill from practicing in the heat? Yes No
8. Do you cough, wheeze, or have trouble breathing during or after activity? Yes No
Do you have asthma? Yes No
Do you have seasonal allergies that require medical treatment? Yes No
9. Have you had any problems with your eyes or vision? Yes No
Do you wear glasses, contacts, or protective eyewear? Yes No
10. Have you ever had a sprain, strain, or swelling after an injury? Yes No
Have you ever broken or fractured any bones or dislocated any joints? Yes No
Have you had any problems with pain or swelling in muscles, tendons, or joints? Yes No

If yes circle all that apply and explain on second page.

head neck back chest shoulder upper arm elbow forearm wrist hand finger

hip thigh knee shin ankle foot toe

