Pre-participation Physical Evaluation

Date of Exam_____

Name_____ Sex_____ Age_____ Date of Birth_____

Grade_____ Sport(s)_____

Address_____ Phone_____ Cell_____

Personal Physician erea_____ Phone_____

In case of emergency, contact: Cell Phone_____

Name_____ Relationship_____ Phone(H)_____ (W)_____

Explain "Yes" answers below.
Circle Questions you don't know the answers to.

1. Have you had a medical illness or injury since your last check up or sports physical? Y or N
2. Have you ever been hospitalized overnight? Y or N
3. Are you currently taking any prescription or non-prescription (over the counter) medications or pills or using an inhaler? Y or N
   Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? Y or N
4. Do you have any allergies (for example: pollen, medicine, food, or stinging insects)? Y or N
5. Have you ever passed out during or after exercise? Y or N
   Have you ever been dizzy during or after exercise? Y or N
   Have you ever had chest pain during or after exercise? Y or N
   Do you get tired more quickly than your friends do during exercise? Y or N
   Have you ever had racing of your heart or skipped heartbeats? Y or N
   Have you had high blood pressure or high cholesterol? Y or N
   Have you ever been told you have a heart murmur? Y or N
   Has any family member of relative died of heart problems or of sudden death before age 50? Y or N
   Have you had a severe viral infection (for example: myocarditis or mononucleosis within the last month? Y or N
   Has a physician ever denied or restricted your participation in sports for any heart problems? Y or N
6. Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus or blisters)? Y or N
7. Have you ever had a head injury or concussion? Y or N
   Have you ever been knocked out, become unconscious or lost your memory? Y or N
   Have you ever had a seizure? Y or N
   Do you have frequent or severe headaches? Y or N
   Have you ever had numbness or tingling in your arms, hands, legs or feet? Y or N
   Have you ever had a stinger, burner or pinched nerve? Y or N
8. Have you ever become ill from exercising in the heat? Y or N
9. Do you cough, wheeze or have trouble breathing during or after activity? Y or N
   Do you have asthma? Y or N
   Do you have seasonal allergies that require medical treatment? Y or N
10. 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, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? Y or N
11. Have you had any problems with your eyes or vision? Y or N
    Do you wear glasses, contacts or protective eyewear? Y or N
12. Have you ever had a sprain, strain or swelling after injury? Y or N
    Have you broken or fractured any bones or dislocated any joints? Y or N
    Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? Y or N
    If yes, circle appropriate box and explain below

Head	Elbow	Hip
Neck	Forearm	Thigh
Back	Wrist	Knee
Chest	Hand	Shin/calf
Shoulder	Finger	Ankle
Upper Arm	Foot	

13. Do you want to weigh more or less than you do now? Y or N
    Do you lose weight regularly to meet weight requirements for your sports? Y or N
14. Do you feel stressed out? Y or N

FEMALES ONLY

15. When was your first menstrual period? _____
    When was your most recent menstrual period?_____
    How much time do you usually have from the start of one period to the start of another?_____
    How many periods have you had in the last year? _____
    What was the longest time between periods in the last year?_____

Explain "yes" answers here:

_____
_____
_____
_____
_____
_____
_____

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_____ Date_____