Pre-Participation Physical Evaluation

Patient's Name: _____ *Date of Birth*: _____ *Age*: _____

The student or parent should complete this questionnaire. Please explain "yes" answers where indicated. If you are not sure of an answer, circle the question for follow up. Thank you.

	Yes	No
1. Have you had a medical illness or injury since your last check-up or sports physical? *If yes, please explain*: _____	☐	☐
2. Do you have an ongoing chronic illness? *If yes, please explain*: _____	☐	☐
3. Have you ever been hospitalized overnight? *If yes, please explain*: _____	☐	☐
4. Have you ever had surgery? *If yes, please explain*: _____	☐	☐
5. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? *If yes, please explain*: _____	☐	☐
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? *If yes, please explain*: _____	☐	☐
7. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)? *If yes, please explain*: _____	☐	☐
8. Have you ever had a rash or hives develop during or after exercise? *If yes, please explain*: _____	☐	☐
9. Have you ever passed out during or after exercise? *If yes, please explain*: _____	☐	☐
10. Have you ever been dizzy during or after exercise? *If yes, please explain*: _____	☐	☐
11. Have you ever had chest pain during or after exercise? *If yes, please explain*: _____	☐	☐
12. Do you get tired more quickly than your friends do during exercise? *If yes, please explain*: _____	☐	☐
13. Have you ever had racing of your heart or skipped heartbeats? *If yes, please explain*: _____	☐	☐
14. Have you had high blood pressure or high cholesterol? *If yes, please explain*: _____	☐	☐
15. Have you ever been told you have a heart murmur? *If yes, please explain*: _____	☐	☐
16. Has any family member or relative died of heart problems or sudden death before age 50? *If yes, please explain*: _____	☐	☐
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? *If yes, please explain*: _____	☐	☐
18. Has a physician ever denied or restricted your participation in sports for any heart problems? *If yes, please explain*: _____	☐	☐
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)? *If yes, please explain*: _____	☐	☐
20. Have you ever had a head injury or concussion? *If yes, please explain*: _____	☐	☐
21. Have you ever been knocked out, become unconscious or lost your memory? *If yes, please explain*: _____	☐	☐
22. Have you ever had a seizure? *If yes, please explain*: _____	☐	☐

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	Yes	No
23. Do you have frequent or severe headaches? *If yes, please explain*: _____	☐	☐
24. Have you ever had numbness or tingling in your arms, hands, legs or feet? *If yes, please explain*: _____	☐	☐
25. Have you ever had a stinger, burner or pinched nerve? *If yes, please explain*: _____	☐	☐
26. Have you ever become ill from exercising in the heat? *If yes, please explain*: _____	☐	☐
27. Do you cough, wheeze or have trouble breathing during or after activity? *If yes, please explain*: _____	☐	☐
28. Do you have asthma? *If yes, please explain*: _____	☐	☐
29. Do you have seasonal allergies that require medical treatment? *If yes, please explain*: _____	☐	☐
30. 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 for your teeth, hearing aid)? *If yes, please explain*: _____	☐	☐
31. Have you had any problems with your eyes or vision? *If yes, please explain*: _____	☐	☐
32. Do you wear glasses, contacts or protective eyewear? *If yes, please explain*: _____	☐	☐
33. Have you ever had a sprain, strain or swelling after injury? *If yes, please explain*: _____	☐	☐
34. Have you broken or fractured any bones or dislocated any joints? *If yes, please explain*: _____	☐	☐
35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? Please check all that apply, and explain where indicated: ☐Head ☐Elbow ☐Hip ☐Neck ☐Forearm ☐Thigh ☐Back ☐Wrist ☐Knee ☐Chest ☐Hand ☐Shin/Calf ☐Shoulder ☐Finger ☐Ankle ☐Upper Arm ☐Foot *If yes, please explain*: _____	☐	☐
36. Do you want to weigh more or less than you do now? *If yes, please explain*: _____	☐	☐
37. Do you lose weight regularly to meet weight requirements for your sport? *If yes, please explain*: _____	☐	☐
38. Do you feel stressed out? *If yes, please explain*: _____	☐	☐

39. Record the dates of your most recent immunizations (shots) for:
Tetanus: _____ Hepatitis B: _____
Measles: _____ Chickenpox: _____

FEMALES ONLY – *Optional* –

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

_____ _____
Signature of parent/guardian *Date*