

## Pre-participation Physical Examination

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Grade: \_\_\_\_\_ Sport(s): \_\_\_\_\_ School: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone # \_\_\_\_\_  
 Personal Physician: \_\_\_\_\_

**In case of emergency, contact:**  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**Athlete and Parent/Guardian:** Please review all questions and answer them to the best of your ability. (Explain any YES answers on back)

- Yes No 1.** Has a doctor ever denied or restricted your participation in sports for any reason?
- Yes No 2.** Do you have any ongoing medical conditions (like diabetes or asthma) or see a physician regularly for any particular problem?
- Yes No 3.** Are you currently taking any prescription or nonprescription (over-the-counter) medicines, herbs, or nutritional supplements?
- Yes No 4.** Do you have allergies to medicines, pollens, foods, or stinging insects?
- Yes No 5.** Have you ever passed or nearly passed out **DURING** exercise?
- Yes No 6.** Have you ever passed or nearly passed out **AFTER** exercise?
- Yes No 7.** Have you ever had discomfort, pain, pressure in your chest during activity?
- Yes No 8.** Does your heart race or skip beats during exercise?
- Yes No 9.** Have you ever had any episodes of shortness of breath, palpitation, history of rheumatic fever, or unusual fatigue?
- Yes No 10.** Has a doctor ever told you that have (circle all that apply):  
                   High blood pressure    A heart murmur  
                   High cholesterol        A heart infection
- Yes No 11.** Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)
- Yes No 12.** Has anyone in your family died for no apparent reason?
- Yes No 13.** Does anyone in your family have a heart problem?
- Yes No 14.** Is there a history of young people in your family who have had congenital or other heart disease (cardiomyopathy, abnormal heart rhythms, or long QT syndrome)?
- Yes No 15.** Has any member or relative died of heart problem or of sudden death before age 50?
- Yes No 16.** Does anyone in your family have Marfan's syndrome?
- Yes No 17.** Have you ever spent the night in a hospital?
- Yes No 18.** Have you ever had surgery?
- Yes No 19.** Have you ever had a stress fracture?
- Yes No 20.** Have you ever been told that you have or have you had an x-ray for atlantoaxial (neck) instability?
- Yes No 21.** Do you regularly use a brace or assistive device?
- Yes No 22.** Where you born without or are you missing any paired organ (kidneys, eyes, ears, testicles, ovaries, etc.)?
- Yes No 23.** Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?
- Yes No 24.** Do you have any rashes, pressure sores, or other skin problems?
- Yes No 25.** Have you had a herpes skin infection?

- Yes No 26.** Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game? (If yes, circle affected area below)
- Yes No 27.** Have you ever had any broken/fractured bones or dislocated joints? (If yes, circle below)
- Yes No 28.** Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, bracing, casting or crutches? (If yes, circle below)

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/Finger	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Lower Leg	Ankle	Foot/Toes

- Yes No 29.** Has a doctor ever told you that you have asthma or allergies?
- Yes No 30.** Do you cough, wheeze, or have difficulty breathing during or after exercise?
- Yes No 31.** Is there anyone in your family who has asthma?
- Yes No 32.** Have you ever used an inhaler or taken asthma medicine?
- Yes No 33.** Have you had infectious mononucleosis (mono) within the last month?
- Yes No 34.** Have you ever had a head injury or concussion?
- Yes No 35.** Have you ever been hit in the head and been confused or lost your memory?
- Yes No 36.** Have you ever had a seizure?
- Yes No 37.** Do you have headaches with exercise?
- Yes No 38.** Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
- Yes No 39.** Have you ever been unable to move your arms or legs after bring hit or falling?
- Yes No 40.** When exercising in heat, do you have severe muscle cramps or become ill?
- Yes No 41.** Have you ever suffered a heat related illness (heat stroke)?
- Yes No 42.** Have you had any problems with your eyes or vision?
- Yes No 43.** Do you wear glasses or contacts?
- Yes No 44.** Do you wear protective eyewear, such as goggles or a face shield?
- Yes No 45.** Are you happy with your weight?
- Yes No 46.** Are you trying to gain or lose weight?
- Yes No 47.** Has anyone recommended that you change your weight or eating habits?
- Yes No 48.** Any other concerns to discuss with the physician?

**FEMALES ONLY**

When was your first menstrual period? \_\_\_\_\_  
 When was your most recent menstrual period? \_\_\_\_\_  
 How many periods have you had in the last year? \_\_\_\_\_

(Explain any YES answers on back)

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 \_\_\_\_\_