Pre-Participation Physical Evaluation HISTORY FORM

This form to be filled out by the patient prior to appointment

Patient Name ___________________________ Sex ___________________________ Date of Birth ______________________

Date of Exam ___________________________ Date of Birth ______________________

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies: □ Yes □ No If yes, please list specific allergy below.
□ Medicines □ Pollens □ Food □ Stinging Insects

GENERAL QUESTIONS

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? If so, please identify below.
   Yes [□] No [□]

3. Have you ever spent the night in the hospital?
   Yes [□] No [□]

4. Have you ever had surgery?
   Yes [□] No [□]

HEART HEALTH QUESTIONS ABOUT YOU

5. Have you ever passed out or nearly passed out during or after exercise?
   Yes [□] No [□]

6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?
   Yes [□] No [□]

7. Does your heart ever race or skip beats (irregular beats) during exercise?
   Yes [□] No [□]

8. Has a doctor ever ordered a test for your heart? (For example, ECG/ECG, echocardiogram) Yes [□] No [□]

9. Do you have a history of seizure disorder?
   Yes [□] No [□]

10. Have you ever had an unexplained seizure?
    Yes [□] No [□]

11. Have you ever had an unexplained fainting?
    Yes [□] No [□]

12. Do you get more tired or short of breath more quickly than your friends during exercise?
    Yes [□] No [□]

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?
    Yes [□] No [□]

14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? Yes [□] No [□]

15. Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?
    Yes [□] No [□]

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?
    Yes [□] No [□]

BONE AND JOINT QUESTIONS

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?
    Yes [□] No [□]

18. Have you ever had any broken or fractured bones or dislocated joints?
    Yes [□] No [□]

19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?
    Yes [□] No [□]

20. Have you ever had a stress fracture?
    Yes [□] No [□]

21. Have you ever had an injury that required an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)
    Yes [□] No [□]

22. Do you regularly use a brace, orthotics, or other assistive device?
    Yes [□] No [□]

23. Have you had a bone, muscle, or joint that bothers you?
    Yes [□] No [□]

24. Do any of your joints become painful, swollen, feel warm, or look red?
    Yes [□] No [□]

25. Do you have any history of juvenile arthritis or connective tissue disease?
    Yes [□] No [□]

MEDICAL QUESTIONS

26. Do you ever cough, wheeze, or have difficulty breathing during or after exercise?
    Yes [□] No [□]

27. Have you ever had an inhaler or taken asthma medicine?
    Yes [□] No [□]

28. Is there anyone in your family who has asthma?
    Yes [□] No [□]

29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?
    Yes [□] No [□]

30. Do you have groin pain or a painful bulge or hernia in the groin area?
    Yes [□] No [□]

31. Have you had infectious mononucleosis (mono) within the last month?
    Yes [□] No [□]

32. Do you have any rashes, pressure sores, or other skin problems?
    Yes [□] No [□]

33. Have you had a herpes or MRSA skin infection?
    Yes [□] No [□]

34. Have you ever had a head injury or concussion?
    Yes [□] No [□]

35. Have you ever had a hit or a blow to the head that caused confusion, prolonged headache, or memory problems?
    Yes [□] No [□]

36. Do you have a history of seizure disorder?
    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 being hit or falling?
    Yes [□] No [□]

40. Have you ever become ill while exercising in the heat?
    Yes [□] No [□]

41. Do you or someone in your family have sickle cell trait or disease?
    Yes [□] No [□]

42. Do you get frequent muscle cramps when exercising?
    Yes [□] No [□]

43. Have you ever had any problems with your eyes or vision?
    Yes [□] No [□]

44. Have you had any eye injuries?
    Yes [□] No [□]

45. Do you wear glasses or contact lenses?
    Yes [□] No [□]

46. Do you wear protective eyewear, such as goggles or a face shield?
    Yes [□] No [□]

47. Do you worry about your weight?
    Yes [□] No [□]

48. Are you trying to or has anyone recommended that you gain or lose weight?
    Yes [□] No [□]

49. Are you on a special diet or do you avoid certain types of foods?
    Yes [□] No [□]

50. Have you ever had an eating disorder?
    Yes [□] No [□]

51. Do you have any concerns that you would like to discuss with a doctor?
    Yes [□] No [□]

52. Have you ever had a menstrual period?
    Yes [□] No [□]

53. How old were you when you had your first menstrual period?
    Yes [□] No [□]

54. How many periods have you had in the last 12 months?
    Yes [□] No [□]

FEMALES ONLY

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    Yes [□] No [□]

56. Have you ever had a menstrual period?
    Yes [□] No [□]

57. How old were you when you had your first menstrual period?
    Yes [□] No [□]

58. How many periods have you had in the last 12 months?
    Yes [□] No [□]

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of patient/student _______________________________ Date ___________________________

Mysdoth/D hat/FORMS/PrePar PE History 08/10/17