



PREPARTICIPATION EVALUATION

HISTORY FORM

NAME: _____ SPORT(S): _____

THIS FORM **MUST BE COMPLETED BY A PARENT OR GUARDIAN!*

MEDICAL HISTORY FORM	Yes	No	If Yes, Please Explain
1. Have you ever had a sports physical before?			
2. Have you ever been denied or restricted by a doctor for participation in sports?			
3. Have you had a medical illness or injury since your physical?			
4. Do you have an ongoing chronic illness? (Please list if yes)			
5. Have you ever been hospitalized?			
6. Have you ever had surgery?			
7. Are you presently taking any prescription or non-prescription medications?			
8. Do you have any allergies (medicine, bees, or other stinging insects)?			
9. Have you ever passed out during or after exercise?			
10. Have you ever been dizzy during or after exercise?			
11. Have you ever had chest pain, discomfort, or shortness of breath during exercise?			
12. Do you have trouble breathing or do you cough during or after activities?			
13. Do you get tired more quickly than your friends do during exercise?			
14. Have you ever had racing of your heart or skipped heartbeats during exercise?			
15. Have you ever had high blood pressure or high cholesterol?			
16. Have you ever been told you have a heart murmur or heart infection?			
17. Has a doctor ever ordered a test for your heart? (Ex: ECG, echocardiogram)			
18. Has anyone in your family died for no apparent reason?			
19. Has any family member/relative died of heart problems or of sudden death before age 50?			
20. Do you know of any heart conditions, sudden cardiac events in family members/relatives?			
21. Have you had a severe viral infection (ex: Myocarditis, Mononucleosis) within last month?			
22. Were you born without or are you missing any organs?			
23. Do you or a member of your family have the sickle cell trait or disease?			
24. Do you have any skin problems? (itching, rashes, acne)			
25. Have you ever had a head injury or concussion? (If so, how many, when, & severity?)			
26. Have you ever had a seizure?			
27. Do you have frequent or severe headaches with exercise?			
28. Have you ever become unconscious?			
29. Have you ever had numbness or tingling in your arms, hands, legs, or feet?			
30. Have you ever lost feeling in your arms or legs?			
31. Have you ever had a stinger, burner, or pinched nerve?			
32. Do you have a problem with your neck or spine?			
33. Have you ever become ill from exercising in the heat?			
34. Have you ever had heat or muscle cramps?			
35. Have you ever been dizzy or passed out in the heat?			
36. Do you have asthma? If yes, how do you treat it?			
37. Do you have seasonal allergies that require medical treatment?			
38. Do you use special equipment (pads, sports brace, neck roll, mouthguard, eye guard)?			
39. Have you had any problems with your eyes or vision?			
40. Do you wear glasses, contacts, or protective eyewear?			
41. Have you ever had a sprain, strain, or swelling after an injury?			
42. Have you ever broken or fractured any bones or dislocated any joints?			
43. Have you ever had a stress fracture? If yes, where?			
44. Do you have pain or swelling in any muscle(s), tendon(s), bone(s), or joints? Please list.			
45. Are you happy with your weight?			
46. Are you trying to gain or lose weight?			
47. Has anyone recommended you change your weight or eating habits?			
48. Do you limit or carefully control what you eat?			
49. Do you have any concerns that you would like to discuss with a doctor?			

Parent/Guardian Signature: _____

Date: _____