

Preparticipation Physical Examination Questionnaire

Name _____ Sex M / F Age _____ Date of Birth _____
 Address _____ Grade (As of Next Sport Season) _____ School _____
 School Sports _____ (Fall) _____ (Winter) _____ (Spring)
IN CASE OF EMERGENCY, CONTACT: Name _____ Relationship _____
 (Parent information) Home Phone _____ Work Phone _____
 Mobile Phone _____ Beeper _____
 Personal Physician's Name _____ Address _____ Phone _____

ALL "YES" ANSWERS MUST BE EXPLAINED (BOX ON BOTTOM RIGHT)

	YES	NO		YES	NO
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	33. Do you wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	34. Do you have any other problem with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	35. Have you ever had dental health problems, or loss of tooth enamel?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you currently taking any prescription or nonprescription (over the counter) medications or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	36. Have you broken or fractured any bones, or dislocated any joints, or been diagnosed with a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever taken any supplements or vitamins to help you improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	37. Have you ever had a sprain, strain, or swelling after injury, or any other problems with pain or swelling in muscles, tendons, bones, or joints that has kept you from participating in sports? <i>If yes, check appropriate box and explain below:</i>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
7. Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
8. Have you ever been dizzy or passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
9. Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf
10. Have you ever had high blood sugar (diabetes)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
11. Do you tire more easily than you feel you should?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm		<input type="checkbox"/> Foot
12. Have you ever been diagnosed with anemia?	<input type="checkbox"/>	<input type="checkbox"/>	38. Have you experienced abdominal discomfort, constipation, diarrhea, and/or bloating?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	39. Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	40. Has there been any unexplained weight loss or weight gain during the past six months?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	41. Are you uncomfortable with your body weight?	<input type="checkbox"/>	<input type="checkbox"/>
16. Has any family member or relative died of heart problems, or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	42. Are you currently following any particular diet or weight-reducing plan?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	43. Do you diet frequently?	<input type="checkbox"/>	<input type="checkbox"/>
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	44. Do you avoid eating certain food groups?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you ever been diagnosed with blood or bleeding disorders?	<input type="checkbox"/>	<input type="checkbox"/>	45. Have you ever tried to control weight by vomiting, using laxatives, diuretics or diet pills?	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you have one kidney or one testicle?	<input type="checkbox"/>	<input type="checkbox"/>	46. Do you have a history of eating disorders?	<input type="checkbox"/>	<input type="checkbox"/>
21. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY		
22. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	47. Has there been a recent change in menstrual patterns?	<input type="checkbox"/>	<input type="checkbox"/>
23. Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	48. At what age did you experience your first menstrual period? _____	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you ever had a seizure or convulsion?	<input type="checkbox"/>	<input type="checkbox"/>	49. When was your most recent menstrual period? ___/___/___		
25. Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	50. How much time do you usually have from the start of one period to the start of another? _____		
26. Have you ever had numbness or tingling in your arms, hands, legs, or feet from a stinger, burner, or pinched nerve, or other condition?	<input type="checkbox"/>	<input type="checkbox"/>	51. How many periods have you had in the last year? _____		
27. Have you ever had heat cramps, heat exhaustion, or heat stroke?	<input type="checkbox"/>	<input type="checkbox"/>	52. What was the longest time between one menstrual cycle and the next in the last year? _____		
28. Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>	Explain "Yes" Answers here (Identify each answer with question number):		
29. Do you have asthma or lung disease?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
30. Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
31. 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, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
32. Have you ever had any problem with your ears or hearing?	<input type="checkbox"/>	<input type="checkbox"/>	_____		

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 _____