

**PREPARTICIPATION PHYSICAL EVALUATION
HEALTH HISTORY QUESTIONNAIRE**

Date: _____

Name: _____ Date of Last Physical: _____

Age: _____

Date of Birth: _____ School: _____

Sex: Male Female

Sport: _____ Home Telephone #: _____ Grade: _____

Physician: _____ Telephone # _____ Fax# _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Telephone # (circle one): cell/home work/

Directions: Please answer the following questions about your medical history. Explain "yes" answers at the bottom of the page.

You must respond to all questions.

1. Have you had or do you currently have:
 - a. A sports physical for this school year? Y/N/Don't know
 - b. An injury or illness since your last exam? Y/N/Don't know
 - c. A chronic or ongoing illness (such as diabetes or asthma)? Y/N/Don't know
 1. Use an inhaler or other prescription medicine to control asthma? Y/N/Don't know
 - d. Any prescribed or over the counter medications that you take on a regular basis? Y/N/Don't know
 - e. Surgery, hospitalization or any emergency room visit(s)? Y/N/Don't know
 - f. Any allergies to medications? Y/N/Don't know
 - g. Any allergies to bee stings, pollen, latex or foods? Y/N/Don't know
 1. Type of reaction: rash, hives, or skin condition? Y/N/Don't know
 2. Take any medication/epipen taken for allergy symptoms? (List below) Y/N/Don't know
 - h. Any anemias or blood disorders? Y/N/Don't know
2. Have you had or do you currently have any of the following *head-related* conditions since your last physical:
 - a. Concussion requiring a physician's evaluation Y/N/Don't know
 1. How often and when? (Answer below)
 - b. Memory loss or been knocked out? Y/N/Don't know
 - c. A seizure? Y/N/Don't know
 - d. Frequent or severe headaches? Y/N/Don't know
3. Have you had or do you currently have any of the following *heart-related* conditions since your last physical:
 - a. Chest pain? (When exercising?) Y/N/Don't know
 - b. Heart murmur? Y/N/Don't know
 - c. High blood pressure or elevated cholesterol level? Y/N/Don't know
 - d. Restriction from sports for heart problems? Y/N/Don't know
 - e. Has any family member or relative:
 1. died of a heart problem before age 35? Y/N/Don't know
 2. died of a heart problem before age 50? Y/N/Don't know
 3. died with no known reason? Y/N/Don't know
 4. died while exercising? During or after? Y/N/Don't know
 5. Marfan's Syndrome? Y/N/Don't know
4. Have you had or do you currently have any of the following *eye, ear, nose, mouth or throat conditions* since your last physical:
 - a. Vision problems? Y/N/Don't know
 1. wear contact, eyeglasses or protective eye wear? (Circle which type) Y/N/Don't know
 - b. Hearing loss or problems? Y/N/Don't know
 1. Wear hearing aids or implants? Y/N/Don't know
 - c. Nasal fractures or frequent nose bleeds? Y/N/Don't know
 - d. Wear braces, retainer or protective mouth gear? Y/N/Don't know
 - e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? Y/N/Don't know

5. Have you had or do you currently have any of the following *neuromuscular/orthopedic conditions* since your last physical:
- a. Been told you had a burner, stinger or pinched nerve? Y/N/Don't know
 - b. A sprain Y/N/Don't know
 - c. A strain Y/N/Don't know
 - d. Swelling or pain in muscles, tendons, bones or joints? Y/N/Don't know
 - e. A dislocated joint(s)? Y/N/Don't know
 - f. Low back pain? Y/N/Don't know
 - g. Fracture(s) or stress fracture(s)? Y/N/Don't know
 - h. Do you wear any protective braces or equipment for any prior injury? Y/N/Don't know
6. Have you had or do you currently have any of the following *general or exercise related conditions* since your last physical:
- a. Difficulty breathing? (During exercise) Y/N/Don't know
 - 1. after running one mile Y/N/Don't know
 - 2. coughing, wheezing or shortness of breath in weather changes? Y/N/Don't know
 - 3. been told you have exercise-induced asthma Y/N/Don't know
 - i. controlled with medication? (List below) Y/N/Don't know
 - ii. Experience dizziness, passing out or fainting? Y/N/Don't know
 - b. Viral infections (e.g. mono, hepatitis)? Y/N/Don't know
 - c. Become tired more quickly than your friends? Y/N/Don't know
 - d. Any of the following skin conditions:
 - 1. acne, contact dermatitis, ringworm, warts, herpes? Y/N/Don't know
 - 2. sun sensitivity Y/N/Don't know
 - e. Weight gain/loss (greater than or less than 10 pounds)? Y/N/Don't know
 - f. Ever had feelings of depression? Y/N/Don't know
 - g. Heat-related problems (dehydration, dizziness, fatigue, headache)? Y/N/Don't know
 - 1. heat exhaustion? (cool, clammy, damp skin) Y/N/Don't know
 - 2. heat stroke? (hot, red, dry skin) Y/N/Don't know

Explain "yes" answers here (include dates):

I authorize the sharing of pertinent medical information to those associated with the Athletic program on a need to know basis.

I certify that the information provided herein is accurate as of the date of these signatures:

Parent/Guardian signature: _____ **Date:** _____

Student signature: _____ **Date:** _____