Pre-participation History and Physical Examination Questionnaire

(to be completed by student/parents prior to examination)

Patient Name: DOB:

	YES	NO	
1.			Has a doctor/provider ever denied or restricted your participation in any sports for any reason?
2.			Have you ever had chest pain, dizziness, fainting or passing out DURING exercise?
3.			Have you ever had chest pain, dizziness, fainting or passing out AFTER exercise?
4.			Has anyone in your family died for no apparent reason?
5.			Have any family members or close relatives died of heart problems or sudden death before age 50?
6.			Were you born without or are you missing a kidney, an eye, or testicle, or any other organ?
7.			Have you ever had a head injury or concussion?
8.			Have you been hit in the head and been confused or lost your memory?
9.			Have you ever had a "stinger" or "burner" or "pinched nerve"?
10.			Have you had any illness/injury recently, or do you have an illness/injury now?
11.			Have you had a medical problem, illness, or injury since your last exam?
12.			Do you have any chronic or recurrent illness?
13.			Have you ever had any illness lasting more than a week?
14.			Have you ever been hospitalized overnight?
15.			Have you had any surgery?
16.			Have you ever had any injuries requiring treatment by a physician?
17.			Do you have any kidney problems?
18.			Are you presently taking ANY medication (including birth control, aspirin, vitamins)?
19.			Do you have ANY allergies (including medicines, bees, food, environmental, etc.)?
20.			Do you tire more easily or quickly than your friends during exercise?
21.			Has any family member or close relative had heart problems before they were age 50?
22.			Do you have any skin problems (acne, itching, rashes, etc.)?
23.			Have you ever had fainting, convulsions, seizures or severe dizziness?
24.			Do you have frequent or severe headaches?
25.			Have you ever had a neck or head injury?
26.			Have you ever had a heat-related exhaustion, stroke, cramps or other problems?
27.			Have you had asthma, trouble breathing, or coughing during or after exercise?
28.			Do you wear eyeglasses, contact lenses, or protective eye wear?
29.			Have you had any problems with your eyes or vision?
30.			Do you have any dental appliances such as braces, bridge, plate or retainer?
31.			Have you ever had a knee injury?
32.			Have you ever had an ankle injury?
33.			Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?
34.			Have you ever had a broken bone or fracture?
35.			Must you use special equipment for competition (pads, braces, neck roll, etc.)?
36.			Has it been more than 5 years since your last tetanus booster shot?
37.			Are you worried about your weight?
38.			FEMALES: Have you had any menstrual problems?
39.			Do you have any medical concerns about participation in your sport?

Comments: (If you answered **YES** to any questions above, **PLEASE EXPLAIN** below.)