

PREPARTICIPATION HISTORY AND PHYSICAL EXAMINATION

This form is not required as long as the conditions of 18.13.0 are met.

Name: _____ Birth Date: _____ Exam Date: _____

Address: _____ City: _____

Zip: _____

Phone: _____ Sport: _____

HISTORY

- | | Yes | No | |
|-----|-----------------------------|--------------------------|--|
| 1 | a. <input type="checkbox"/> | <input type="checkbox"/> | Have you had any illness/injury recently, or do you have an illness/injury now? |
| | b. <input type="checkbox"/> | <input type="checkbox"/> | Have you had a medical problem, illness or injury since your last exam? |
| | c. <input type="checkbox"/> | <input type="checkbox"/> | Do you have any chronic or recurrent illness? |
| | d. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any illness lasting more than a week? |
| | e. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized overnight? |
| | f. <input type="checkbox"/> | <input type="checkbox"/> | Have you had any surgery other than tonsillectomy? |
| | g. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any injuries requiring treatment by a physician? |
| | h. <input type="checkbox"/> | <input type="checkbox"/> | Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Are you presently taking ANY medications (including birth control pill, vitamin, aspirin, etc.)? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have ANY allergies (medicines, bees, foods, or other factors)? |
| 4 | a. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had chest pain, dizziness, fainting, passing out during or after exercise? |
| | b. <input type="checkbox"/> | <input type="checkbox"/> | Do you tire more easily or quickly than your friends during exercise? |
| | c. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any problem with your blood pressure or your heart? |
| | d. <input type="checkbox"/> | <input type="checkbox"/> | Have any close relatives had heart problems, heart attack or sudden death before they were age 50? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any skin problems (acne, itching, rashes, etc.)? |
| 6 | a. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had fainting, convulsions, seizures or severe dizziness? |
| | b. <input type="checkbox"/> | <input type="checkbox"/> | Do you have frequent severe headaches? |
| | c. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a "stinger" or "burner" or "pinched nerve"? |
| | d. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been "knocked out" or "passed out"? |
| | e. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a neck or head injury? |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems? |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had asthma, or trouble breathing, or cough during or after exercise? |
| 9 | a. <input type="checkbox"/> | <input type="checkbox"/> | Do you wear eyeglasses, contact lenses or protective eye wear? |
| | b. <input type="checkbox"/> | <input type="checkbox"/> | Have you had any problem with your eyes or vision? |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear any dental appliance such as braces, bridge, plate, retainer? |
| 11 | a. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a knee injury? |
| | b. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an ankle injury? |
| | c. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever injured any other joint (shoulder, wrist, fingers, etc.)? |
| | d. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a broken bone (fracture)? |
| | e. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a cast, splint, or had to use crutches? |
| | f. <input type="checkbox"/> | <input type="checkbox"/> | Must you use special equipment for competition (pads, braces, neck roll, etc.)? |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | Has it been more than 5 years since your last tetanus booster shot? |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> | Are you worried about your weight? |
| 14. | <input type="checkbox"/> | <input type="checkbox"/> | FEMALES: Have you any menstrual problems? |
| 15. | <input type="checkbox"/> | <input type="checkbox"/> | Have you any medical concerns about participating in your sport? |

***** ATHLETE SHOULD NOT WRITE BELOW THIS LINE *****

EXAMINER'S COMMENTS ON ALL "YES" ANSWERS (refer to question number):
