

Supplement A Page 1

Preparticipation Physical Evaluation

Date of Exam _____ History form

Name _____ Sex _____ Age _____ Date of Birth _____

	Yes/No		Yes/No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/> <input type="checkbox"/>	23. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/> <input type="checkbox"/>
2. Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/> <input type="checkbox"/>	24. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/> <input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over the counter) medicines or pills? If so, list below.	<input type="checkbox"/> <input type="checkbox"/>	25. Have you had infectious mononucleosis (mono) within the last six months?	<input type="checkbox"/> <input type="checkbox"/>
4. Do you have allergies to pollens, foods or stinging insects?	<input type="checkbox"/> <input type="checkbox"/>	26. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/> <input type="checkbox"/>
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/> <input type="checkbox"/>	27. Have you had a herpes skin infection?	<input type="checkbox"/> <input type="checkbox"/>
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/> <input type="checkbox"/>	28. Have you ever been treated for MRSA?	<input type="checkbox"/> <input type="checkbox"/>
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/> <input type="checkbox"/>	29. Have you ever had a head injury or concussion?	<input type="checkbox"/> <input type="checkbox"/>
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/> <input type="checkbox"/>	30. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/> <input type="checkbox"/>
9. Has a doctor ever told you that you have (<i>check all that apply</i>)	<input type="checkbox"/> <input type="checkbox"/>	31. Have you ever had a seizure?	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol		32. Do you have headaches with exercise?	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> A heart murmur <input type="checkbox"/> A heart infection		33. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/> <input type="checkbox"/>
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	<input type="checkbox"/> <input type="checkbox"/>	34. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/> <input type="checkbox"/>
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/> <input type="checkbox"/>	35. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/> <input type="checkbox"/>
12. Does anyone in your family have a heart problem?	<input type="checkbox"/> <input type="checkbox"/>	36. Do you have any problems with your eyes or vision?	<input type="checkbox"/> <input type="checkbox"/>
13. Has any family member or relative died of heart problems or sudden death before age 50?	<input type="checkbox"/> <input type="checkbox"/>	37. Do you wear glasses or contact lenses?	<input type="checkbox"/> <input type="checkbox"/>
14. Does anyone in your family have Marfan Syndrome?	<input type="checkbox"/> <input type="checkbox"/>	38. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/> <input type="checkbox"/>
15. Have you ever spent the night in a hospital?	<input type="checkbox"/> <input type="checkbox"/>	39. Are you happy with your weight?	<input type="checkbox"/> <input type="checkbox"/>
16. Have you ever had surgery?	<input type="checkbox"/> <input type="checkbox"/>	40. Are you trying to gain or lose weight?	<input type="checkbox"/> <input type="checkbox"/>
17. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game? <i>If yes, check affected area below:</i>	<input type="checkbox"/> <input type="checkbox"/>	41. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Upper arm <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm		42. Do you have any concerns that you would like to discuss with a medical professional?	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Hand/ fingers <input type="checkbox"/> Chest <input type="checkbox"/> Upper back <input type="checkbox"/> Lower back <input type="checkbox"/> Hip <input type="checkbox"/> Thigh		FEMALES ONLY	
<input type="checkbox"/> Knee <input type="checkbox"/> Calf /shin <input type="checkbox"/> Ankle <input type="checkbox"/> Foot/toes		43. How old were you when you had your first menstrual period? _____	
18. Have you ever had a stress fracture?	<input type="checkbox"/> <input type="checkbox"/>	44. How many periods have you had in the last year? _____	
19. Have you ever had an x-ray of your neck or been told you have a neck instability?	<input type="checkbox"/> <input type="checkbox"/>	45. When was your most recent period? _____	
20. Do you regularly use a brace or assistive device?	<input type="checkbox"/> <input type="checkbox"/>	Explain all "yes" answers from any of the questions here:	
21. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/> <input type="checkbox"/>	_____	
22. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/> <input type="checkbox"/>	_____	

I hereby state, to the best of my knowledge that the answers to the above medical questions are correct and accurate.

Signature of Athlete: _____ Date _____

Medical History reviewed by: _____ Date _____

