

Preparticipation Screening

HISTORY

Name _____ Race _____ Sex _____ Age _____ Date of Exam _____
 Grade _____ School (Upcoming Year) _____ Sport(s) _____ Date of Birth _____
 Address _____ City _____ State _____ Zip _____ Phone _____
 Personal Physician _____ Physician Phone _____
In case of emergency, contact
 Name _____ Relationship _____ Phone (H) _____ (W) _____

Circle questions you don't know the answers to. Explain "Yes" answers below:

	Yes	No		Yes	No
1. Have you ever passed out during or after exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain during or after exercise? Do you get tired more quickly than your friends do during exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?.....	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Have you had high blood pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Have you had high cholesterol?.....	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told you have a heart murmur?....	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Has any family member or relative died of heart problems or of sudden death before age 50?.....	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any conditions involving your heart? Has a physician ever denied or restricted your participation in sports for any heart problems?.....	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
2. Have you had a medical illness or injury since your last checkup or sports physical?.....	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been hospitalized overnight?..... Have you ever had surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>		<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?..... Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?.....	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?..... Have you ever had a rash or hives develop during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?.....	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
* 7. Have you ever had a head injury or concussion?..... Have you ever been knocked out, become unconscious or lost your memory?..... Have you ever had a seizure?..... Do you have frequent or severe headaches?..... Have you ever had numbness or tingling in your arms, hands, legs or feet?..... Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
* 8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
9. Do you cough, wheeze or have trouble breathing during or after activity?..... Do you have asthma?..... Do you have seasonal allergies that require medical treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
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