

**Preparticipation Screening - AIA Approved**

**HISTORY**

Name \_\_\_\_\_ Race \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Exam \_\_\_\_\_  
 Grade \_\_\_\_\_ School (Upcoming Year) \_\_\_\_\_ Sport(s) \_\_\_\_\_  
 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?..... Have you ever had racing of your heart or skipped heartbeats?..... Have you had high blood pressure?..... Have you had high cholesterol?..... Have you ever been told you have a heart murmur?..... Has any family member or relative died of heart problems or of sudden death before age 50?..... 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"/>	10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth or hearing aid)?.....	<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"/>	11. Have you had any problems with your eyes or vision?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been hospitalized overnight?..... Have you ever had surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had a sprain, strain or swelling after injury?..... Have you broken or fractured any bones or dislocated any joints?..... Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? Head _____ Elbow _____ Thigh _____ Neck _____ Forearm _____ Knee _____ Back _____ Wrist _____ Shin/calf _____ Chest _____ Hand _____ Ankle _____ Shoulder _____ Finger _____ Foot _____ Upper arm _____ Hip _____	<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"/>	<i>If yes, check appropriate box and explain below.</i> 13. Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your sport?.....	<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"/>	14. Do you feel stressed out?.....	<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"/>	15. Record dates of your most recent immunizations (shots) for: Tetanus _____ MMR _____ Hepatitis B _____ Chickenpox _____	<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"/>	<b>Females Only</b> 16. Are you having irregular periods?.....	<input type="checkbox"/>	<input type="checkbox"/>
* 8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Explain "Yes" answers here:</b> _____ _____ _____ _____		
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"/>	_____ _____ _____		

I understand and give permission for my child to have a free sports screening with an EKG and ECHO (if necessary). This information may be used for medical research (no names would be mentioned).

Signature of Parent/Guardian/Student if over 18 \_\_\_\_\_