TOPS Free Sports Screenings - Team of Physicians for Students

Preparticipation Screening - AIA Approved

HISTORY Date of Exam _____

Name _____ Race _____ Sex _____ Age _____ Date of Birth _____

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
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?		
2. Have you had a medical illness or injury since your last checkup or sports physical?		
3. Have you ever been hospitalized overnight?		
Have you ever had surgery?		
* 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?		
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?		
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?		
* 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?		
* 8. Have you ever become ill from exercising in the heat?		
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?		

	Yes	No
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)?		
11. Have you had any problems with your eyes or vision?		
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	

If yes, check appropriate box and explain below.

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?		
14. Do you feel stressed out?		
15. Record dates of your most recent immunizations (shots) for:		

Tetanus _____ MMR _____

Hepatitis B _____ Chickenpox _____

Females Only

16. Are you having irregular periods?		
17. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
18. Have you ever been tested for sickle cell trait?		

Explain "Yes" answers here: _____

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 _____

Date _____ School (Upcoming Year) _____ Rev. 3/11