

**PRE - PARTICIPATION  
 SPORTS SCREENING**

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 School \_\_\_\_\_ Grade \_\_\_\_\_ Sports \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Personal Physician \_\_\_\_\_ Physician's Phone \_\_\_\_\_

**Medical History Questionnaire - This section must be completed before your examination. Include dates/age of any problems and explain ALL "Yes" answers in the space below the questions.**

- |  |                          |                          |  |                          |                          |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
|  | <b>YES</b>               | <b>NO</b>                |  | <b>YES</b>               | <b>NO</b>                |
| 1. Do you have any ongoing medical conditions?<br><input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have you ever had a sprained, broken, dislocated or repeated swelling or pain of any bones or joints that caused you to miss a practice or game?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever spent the night in a hospital?  | <input type="checkbox"/> | <input type="checkbox"/> | 20. Are any joints CURRENTLY bothering you?<br><input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Wrist<br><input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Ankle <input type="checkbox"/> Foot | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had surgery?  | <input type="checkbox"/> | <input type="checkbox"/> | 21. Do you use any special equipment (splints, neck rolls, mouth guards)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you currently taking any medications or pills?  | <input type="checkbox"/> | <input type="checkbox"/> | 22. Have you ever had a stinger, burner or pinched nerve?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any allergies (medicine, bee stings, etc.)?   | <input type="checkbox"/> | <input type="checkbox"/> | 23. Have you ever been told you have Sickle Cell Trait or Sickle Cell Disease?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out or nearly passed out DURING or AFTER exercise?   | <input type="checkbox"/> | <input type="checkbox"/> | 24. Have you had any medical problems or injuries since your last evaluation?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had chest pains DURING or AFTER exercise?   | <input type="checkbox"/> | <input type="checkbox"/> | 25. Has a doctor ever Denied or Restricted your participation in sports for any reason?<br>When and why? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had high blood pressure?  | <input type="checkbox"/> | <input type="checkbox"/> | 26. When was your last tetanus vaccine? _____<br>(FEMALES ONLY)  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been told you have a heart murmur?  | <input type="checkbox"/> | <input type="checkbox"/> | 27. Have you ever had a menstrual period?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Does your heart ever race or skip beats (irregular beats) during exercise?   | <input type="checkbox"/> | <input type="checkbox"/> | 28. If so, how old were you when you had your first menstrual period? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has any family member died of heart problems or had an unexplained sudden death BEFORE age 50?   | <input type="checkbox"/> | <input type="checkbox"/> | 29. How many periods have you had in the last 12 months? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you get lightheaded or feel more short of breath than expected during exercise?   | <input type="checkbox"/> | <input type="checkbox"/> | 30. What was the longest time between our periods last year? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever had a seizure?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 14. Have you ever had a head injury or concussion?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 15. Have you ever been knocked unconscious?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 16. Do you have headaches with exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 17. Do you have any problems with your eyes or vision?<br>Do you wear <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Eye Protection?            | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 18. Do you have only one working organ of usually paired organs (such as only one eye, kidney, testicle, etc.)?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |

**Explain all "Yes" answers by question number and indicate date/age for each item (Example: #3: Right arm fracture in 2015):**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**I/We hereby state that, to the best of my/our knowledge, the answers to the above questions are correct. I/We understand that by performing this examination, the undersigned physician does not assume responsibility for the medical care of this Individual.**

Signature of Athlete \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent or Guardian (if athlete is under 18) \_\_\_\_\_ Date \_\_\_\_\_

	Blood Pressure	HEENT	Skin	Heart	Lungs	Musculoskeletal	Flexibility/Strength
NORMAL							
ABNORMAL							

While this does not constitute a complete physical examination nor replace the need for periodic health evaluations by a family physician, this individual appears to be physically capable of participation in interscholastic sports as of this date, except as indicated below.

- Cleared for sports without restrictions: \_\_\_\_\_  
 Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_  
 Not Cleared

At this athlete's screening exam, the following is/are noted:

Condition/Sign/Symptoms with Simple Explanation/Recommendations

- Elevated (High) Blood Pressure. Increase in pressures in the artery during the beating and resting heart. Maximum normal (age group) \_\_\_ / \_\_\_  
 Heart Murmur. Flow of blood through the heart which is audible. In this case, it is: 0 "Functional" (normal) 0 Abnormal.  
 Asthma. Blockage of small airways in the lung.  Use inhaler as prescribed and 30 minutes before exercise.  
 Allergic Reactions to Stings or Bites. (includes whole body swelling & shortness of breath)  Epinephrine injector should be available at all times.  
 Diabetes. Abnormal sugars and sugar metabolism.  Continue close monitoring with M.D.  
 Scoliosis. Curvature of the spine.  Continue close monitoring with M.D.  
 Orthopaedic Problem. Being seen by M.D. for this condition.  Should be cleared for play by M.D.  
 Concussion. Further evaluation required before athletic participation permitted.  
 Other: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_