Name _____ ***Preparticipation Sports Physical***

DOB _____ **Age** _____ **Date** _____

Supplemental Sports History (to be completed by parent/patient)

School and grade level .....

Sport(s) planned .....

Answer these questions. Circle questions you don't know the answers to. ***Explain "Yes" answers below.***

Y or N 1. Has a doctor ever denied or restricted your participation in sports for any reason?

Y or N 2. Do you have an ongoing medical condition (like diabetes or asthma)?

Y or N 3. Are you currently taking any prescription or non-prescription (over-the-counter) medicines or pills?

Y or N 4. Do you have allergies to medicines, pollens, foods, or stinging insects?

Y or N 5. Have you ever passed out or nearly passed out DURING exercise?

Y or N 6. Have you ever passed out or nearly passed out AFTER exercise?

Y or N 7. Have you ever had discomfort, pain, or pressure in your chest during exercise?

Y or N 8. Does your heart race or skip beats during exercise?

Y or N 9. Has a doctor ever told you that you have (check all that apply)
❑High blood pressure ❑High cholesterol ❑A heart murmur ❑A heart infection

Y or N 10. Has a doctor ever ordered a test for your heart? (such as EKG, echocardiogram)?

Y or N 11. Has anyone in your family died for no apparent reason?

Y or N 12. Does anyone in your family have a heart problem?

Y or N 13. Has any family member or relative died of heart problems or of sudden death before age 50?

Y or N 14. Does anyone in your family have Marfan syndrome?

Y or N 15. Have you ever spent the night in a hospital?

Y or N 16. Have you ever had surgery?

Y or N 17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or a game? If yes, indicate body part and date of injury.

Y or N 18. Have you ever had any broken or fractured bones or dislocated joints? If yes, indicate body part and date of injury.

Y or N 19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, indicate body part and date of injury.

Y or N 20. Have you ever had a stress fracture?

Y or N 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?

Y or N 22. Do you regularly use a brace or assistive device?

Y or N 23. Has a doctor ever told you that you have asthma or allergies?

Y or N 24. Do you cough, wheeze, or have difficulty breathing during or after exercise?

Y or N 25. Is there anyone in your family who has asthma?

Y or N 26. Have you ever used an inhaler or taken asthma medicine?

Y or N 27. Were you born without or are you missing a kidney, a testicle, or any other organ?

Y or N 28. Have you had infectious mononucleosis (mono) within the last month?

Y or N 29. Do you have any rashes, pressure sores, or other skin problems?

Y or N 30. Have you had a herpes skin infection?

Y or N 31. Have you ever had a head injury or concussion?

Y or N 32. Have you been hit in the head and been confused or lost your memory?

Y or N 33. Have you ever had a seizure?

Y or N 34. Do you have headaches with exercise?

Y or N 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?

Y or N 36. Have you ever been unable to move your arms or legs after being hit or falling?

Y or N 37. When exercising in the heat, do you have severe muscle cramps or become ill?

Y or N 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?

Y or N 39. Have you had any problems with your eyes or vision?

Y or N 40. Do you wear glasses or contact lenses?

Y or N 41. Do you wear protective eyewear, such as goggles or a face shield?

Y or N 42. Are you happy with your weight?

Y or N 43. Are you trying to gain or lose weight?

Y or N 44. Has anyone recommended you change your weight or your eating habits?

Y or N 45. Do you limit or carefully control what you eat?

Y or N 46. Do you have any concerns that you would like to discuss with the doctor?

I certify that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

Assessment

❑Cleared for full sports participation/no restrictions

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_____

Plan

_____

_____

❑ Naomi Sato, M.D. ❑ Robyn Kimura, M.D.