**Sports Physical Health History**

**Patient Name:**       **Date** **of** **Birth**:

**Gender**:       **Age**:       **School**:       **Grade**:

**What sports do you play?**

**Street Address:**

**City:**       State:       Zip:

**Parent’s Email Address:**

**Phone**:

**Please list all of the PRESCRIPTION AND OTC MEDICATIONS that you are currently taking:**

**Medication**:       **Dosage**:       **Frequency**: per [ ]  Day [ ]  Wk [ ]  Mo

**Medication**:       **Dosage**:       **Frequency**: per [ ]  Day [ ]  Wk [ ]  Mo

**Medication**:       **Dosage**:       **Frequency**: per [ ]  Day [ ]  Wk [ ]  Mo

**Please list all of the SUPPLEMENTS that you are currently taking:**

**Medication**:       **Dosage**:       **Frequency**: per [ ]  Day [ ]  Wk [ ]  Mo

**Other Frequency (please describe):**

**Medication**:       **Dosage**:       **Frequency**: per [ ]  Day [ ]  Wk [ ]  Mo

**Other Frequency (please describe):**

**Medication**:       **Dosage**:       **Frequency**: per [ ]  Day [ ]  Wk [ ]  Mo

**Other Frequency (please describe):**

**ALLERGIES:**

Do You have any allergies? [ ] Yes [ ] No If yes, please identify and specify below:

[ ] Medicines [ ] Pollens [ ] Food [ ] Stinging Insects [ ]  Other

Specify any ALLERGIES TO MEDICATIONS:

Specify ALLERGIES TO POLLENS, FOOD AND INSECT ALLERGIES:

|  |  |  |
| --- | --- | --- |
| **General Questions** | **YES** | **NO** |
| 1a. Has a doctor ever denied or restricted your participation in sports for any reason? |  x[ ]  |  [ ]  |
| 1b. Have you had a medical illness or injury since your last sports physical? |  [ ]  |  [ ]  |
| 2.. Do you have any ongoing medical conditions such as Asthma, Anemia, Diabetes, Infections..ect? If yes, please identify below:       |  [ ]  |  [ ]  |
| 3. Have you ever spent the night in the hospital? |  [ ]  |  [ ]  |
| 4. Have you ever had surgery? |  [ ]  |  [ ]  |
| **Heart Health Questions** | **YES** | **NO** |
| 5. Have you ever passed out or nearly passed out during or after exercise? |  [ ]  |  [ ]  |
| 6. Have you ever had pain, tightness or pressure in your chest during exercise? |  [ ]  |  [ ]  |
| 7. Does your heart ever race or skip beats during exercise? |  [ ]  |  [ ]  |
| 8. Has a doctor ever told you that you have any heart problems? If yes, please identify below: High blood pressure High cholesterol Kawasaki disease  Heart murmur Heart infection Specify:       |  [ ]  |  [ ]  |
| 9. Has a doctor ever ordered a test for your heart?(ECG/EKG, echo, ect)       |  [ ]  |  [ ]  |
| 10. Do you get lightheaded or feel more short of breath than expected during exercise? |  [ ]  |  [ ]  |
| 11. Have you ever had an unexpected seizure? |  [ ]  |  [ ]  |
| 12. Do you get more tired or short of breath more quickly than your friends during exercise? |  [ ]  |  [ ]  |
| **Family Heart Health Questions** | **YES** | **NO** |
| 13. Have any of your relatives/family members died of heart problems or had any unexplained/unexpected death before age 50? (including drowning, unexplained car accident, or sudden infant death syndrome) |  [ ]  |  [ ]  |
| 14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmic right ventricular cariomyopathy, long/short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? |  [ ]  |  [ ]  |
| 15. Does anyone in your family have a heart problem, pacemaker or other device? |  [ ]  |  [ ]  |
| 16. Has anyone in your family had unexplained seizures or near drowning? |  [ ]  |  [ ]  |
| **Bone and Joint Questions** | **YES** | **NO** |
| 17. Have you ever had a bone, muscle, ligament or tendon injury that caused you to miss practice/games? |  [ ]  |  [ ]  |
| 18. Have you ever broken/fractured bones or dislocated joints? |  [ ]  |  [ ]  |
| 19. Have you ever had an injury that required x-rays, MRI, CT scan, injection, therapy, a brace/cast or crutches? |  [ ]  |  [ ]  |
| 20. Have you ever had a stress fracture? |  [ ]  |  [ ]  |
| 21. Have you ever been told that you have or have had an xray for neck instability or atlantoaxial instability? (down syndrome or dwarfism) |  [ ]  |  [ ]  |
| 22. Do you regularly use a brace, orthotics, or other assistive device? |  [ ]  |  [ ]  |
| 23. Do any of your joints become painful, swollen, feel warm or look red? |  [ ]  |  [ ]  |
| 24. Do you have a history of juvenile arthritis or connective tissue disease? |  [ ]  |  [ ]  |
| 25. Do you have a bone, muscle or joint injury that bothers you? If yes, please identify below: Head Neck Back Chest Shoulder Upper Arm Elbow Forearm Wrist Hand Hip Thigh Knee Shin/Calf Ankle FootSpecify:       |   |   |
| **Medical Questions** | Yes | No |
| 26. Do you cough, wheeze or have difficulty breathing during or after exercise? |  [ ]  |  [ ]  |
| 27. Have you ever used an inhaler or taken asthma medicine? |  [ ]  |  [ ]  |
| 28. Is there anyone in your family who has asthma? |  [ ]  |  [ ]  |
| 29. Were you born without or are you missing a kidney, eye, testicle (males), your spleen or other organ? |  [ ]  |  [ ]  |
| 30. Do you have groin pain or a painful bulge or hernia in the groin area?  |  [ ]  |  [ ]  |
| 31. Have you had infectious mononucleosis within the last month? |  [ ]  |  [ ]  |
| 32. Do you have any rashes, pressure sores or other skin problems? |  [ ]  |  [ ]  |
| 33. Have you ever had a herpes or MRSA skin infection? |  [ ]  |  [ ]  |
| 34. Have you ever had a head injury or concussion? |  [ ]  |  [ ]  |
| 35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache or memory problems? |  [ ]  |  [ ]  |
| 36. Do you have a history of seizure disorder? |  [ ]  |  [ ]  |
| 37. Do you get headaches with exercise? |  [ ]  |  [ ]  |
| 38. Have you ever had numbness, tingling or weakness in your arms of legs after being hit or falling? |  [ ]  |  [ ]  |
| 39. Have you ever been unable to move your arms or legs after being hit or falling? |  [ ]  |  [ ]  |
| 40. Have you ever become ill while exercising in the heat? |  [ ]  |  [ ]  |
| 41. Do you get frequent muscle cramps while exercising? |  [ ]  |  [ ]  |
| 42. Do you or someone in you family have sickle cell trait or disease? |  [ ]  |  [ ]  |
| 43. Have you had any problems with your eyes or vision? |  [ ]  |  [ ]  |
| 44. Have you had any eye injuries? |  [ ]  |  [ ]  |
| 45. Do you wear glasses or contacts? |  [ ]  |  [ ]  |
| 46. Do you wear protective eyewear such as goggles or a face shield? |  [ ]  |  [ ]  |
| 47. Do you worry about your weight? |  [ ]  |  [ ]  |
| 48. Are you trying to or has anyone recommended that you gain or lose weight? |  [ ]  |  [ ]  |
| 49. Are you on a special diet or do you avoid certain types of foods? |  [ ]  |  [ ]  |
| 50. Have you ever had an eating disorder? |  [ ]  |  [ ]  |
| 51. Do you have any concerns that you would like to discuss with a doctor? |  [ ]  |  [ ]  |
| **Females Only** | Yes | No |
| 52. Have you ever had a menstrual period? |  [ ]  |  [ ]  |
| 53. How old were you when you had your first menstrual period? Age \_\_\_\_\_\_\_ |  [ ]  |  [ ]  |
| 54. How many periods have you had in the last 12 months? # \_\_\_\_\_\_\_ |  [ ]  |  [ ]  |

Explain YES Answers Below:

In order to SAVE TIME during your sports physical, please explain all “YES” answers below. Include the question number and then the explanation.

Yes Answers: