

Pierpont Geer RN, Stephanie Haigh LPN

PRE-PARTICIPATION HISTORY

Name: _____ Sex: M F Age: _____ Date of Birth: _____ Grade: _____
Address: _____ Telephone: _____
Personal Physician: _____ Physician Tel. #: _____ Sport: _____

Attention: Please be sure to read carefully and answer the following questions to the best of your knowledge

General Medical History:

- | | | | |
|--|-----|----|--------|
| 1. Do you have asthma? | Yes | No | |
| 2. Do you have diabetes? | Yes | No | |
| 3. Do you have high blood pressure? | Yes | No | |
| 4. Do you have seizures? | Yes | No | |
| 5. Do you have sickle cell trait? | Yes | No | |
| 6. Do you have any other major medical problem? | Yes | No | |
| 7. Have you ever been hospitalized or had surgery? | Yes | No | |
| 8. Do you cough, wheeze, or have trouble breathing with exercise? | Yes | No | |
| 9. Do you use an inhaler? | Yes | No | |
| 10. Do you have a single organ (e.g., testicle, kidney)? | Yes | No | |
| 11. Are you currently taking any medicines or do you take any medicines on a regular basis (prescription or over-the-counter)? | Yes | No | |
| 12. Have you ever taken any supplements or vitamins to help with weight loss, weight gain or to improve performance? | Yes | No | |
| 13. Do you have any allergies (e.g., seasonal, insects, food or medicines)? | Yes | No | |
| 14. Have you ever had a rash or hives develop during or after exercise? | Yes | No | |
| 15. Do you have any skin problems other than acne? | Yes | No | |
| 16. Have you ever had a rash or hives develop during or after exercise? | Yes | No | |
| 17. Have you ever had numbness or tingling in your arms, hands, legs, or feet? | Yes | No | |
| 18. Have you ever had a stinger, burner, or pinched nerve? | Yes | No | |
| 19. Have you ever become ill from exercising in the heat? | Yes | No | |
| 20. Have you had mononucleosis or any significant illness in the last 60 days? | Yes | No | |
| 21. Do you have trouble with your eyes/vision/wear glasses? | Yes | No | |
| 22. Do you have trouble with your hearing/wear hearing aid(s)? | Yes | No | |
| 23. Do you want to weigh more or less than you do now? | Yes | No | |
| 24. Do you lose weight regularly to meet weight requirements for your sport or other reasons? | Yes | No | Yes No |
| 25. Do you feel stressed out, tired or depressed? | Yes | No | |
| 26. Are there any other issues you would like to discuss with the doctor? | Yes | No | |
| 27. Are your immunizations up to date? | Yes | No | |
| <u>FEMALES ONLY:</u> 28. Are your periods regular (i.e., every month)? | Yes | No | |
| 29. Are your periods heavy? | Yes | No | |

Explain "YES" answers here (attach another sheet of paper if needed):

Cardiac History:

- | | | | | |
|---|-----|----|-----|----|
| 1. Have you ever passed out during or after exercise? | Yes | No | | |
| 2. Have you ever been dizzy during or after exercise? | Yes | No | | |
| 3. Have you ever had chest pain or chest pressure during or after exercise? | Yes | No | | |
| 4. Do you tire easily or more quickly than your friends during exercise? | Yes | No | | |
| 5. Have you ever had racing or you heart or skipped heartbeats? | Yes | No | | |
| 6. Have you ever been told you had a heart murmur? | Yes | No | | |
| 7. Have you ever been told you have an enlarged or weak heart? | Yes | No | | |
| 8. Has any member of your family | | | Yes | No |
| a) died of heart problems or sudden death before age 50? | | | Yes | No |
| b) been told they had a serious heart problem before age 50? | | | Yes | No |
| c) been told they had Marfan's syndrome? | | | Yes | No |
| 9. Has a physician ever denied or restricted your participation in sports? | Yes | No | | |

Explain "YES" answers here (attach another sheet of paper if needed):

Orthopedic History:

- | | | | |
|--|----------------|-------------|--------------------------------|
| 1. Have you ever broken or fractured any bones? | Yes | No | |
| 2. Have you ever subluxed or dislocated any joint? | Yes | No | |
| 3. If you have had problems with any of the following, please check: | | | |
| Neck, spine or back _____ | Shoulder _____ | Elbow _____ | Wrists, hands or fingers _____ |
| Ankles, feet or toes _____ | Hips _____ | Knee _____ | Other (identify) _____ |

Explain "YES" answers here (include date of injury, if known):

Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics - As the parent or legal guardian of the above named student-athlete, I give my permission for his/her participation in athletic events. I also give my permission for the physical evaluation for that participation, unless I check the box below for the physical evaluation to be complete by our primary care physician. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know the risk of injury during participation in sports through meetings, written information or by some other means. My signature indicates that, to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

_____ Check only if you would like the physical evaluation completed by your primary care physician. By checking this, I also will provide this form and proper documentation of the physical evaluation to the Hudson Jr./Sr. High School Nurse to be reviewed by the school health professional.

Athlete Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____