* Only Fill out if you do NOT need a physical.

SPORTS PARTICIPATION HEALTH RECORD UPDATE

Name		Grade	Age	_Birth Date	
	none Number		Today's Date		
	RIM HEALTH HISTORY:				
betwee	en preparticipation evaluations.	Positive resp	onses shoul	d prompt a medical	
evalua	tion. This form is to be comple	eted by the ath	lete and par	ent.	
1.	Over the next 12 months, I wi	ite in the fol	lowing sports:		
	a				
	b				
	c				
2.	d. Have you missed more than the	ree consecuti	ve days of p	articipation in usual	
	activities because of an injury	this past year	?Yes	No	
	If yes, please indicate:	18 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
	G., C				
	b. Type of injury				
3.	Have you missed more than fi	ve consecutiv	e days of par	rticipation in usual	
	activities because of an illness	diagnosed the	at has not be	en resolved in this past	
	year? YesNo	Č			
	If yes, please indicate type of	illness			
4.	Have you had a seizure, concu	ission or beer	unconsciou	s for any reason in the	
	last year? Yes	No		•	
5.	Have you had surgery or been	hospitalized i	n the past ye	ear?	
	Yes No				
	If yes, please indicate:				
	a. Reason for hospitalization				
		W			
6.	List all medications you are pr	resently taking	and what co	ondition it is for.	
••	a.				
	b.				
7.	Are you worried about any pro	oblem or cond	ition at this	time?	
•	Yes No				
	If yes, please explain				
	11 yes, preuse enpum			,	
8.	Do you have any emotional co	oncerns or diff	iculties that	affect mood, appetite.	
0.	interest level, outlook, sleep, o	or perception of	of reality? Y	es No	
	If yes, please explain				
	ii yes, piedse explain				
I hereb	y state that to the best of my ki	nowledge, my	answers to t	he above questions are	
2011000	•				
Signati	are of athlete			Date	
		- CONTROL - MARCON - CONTROL - CONTR			
Signati	are of parent			Date	

*Only Fill out if physical is needed

Preparticipation Physical Evaluation

HISTORY FORM

NameSchoolSport(s)		
AddressPhone Personal physician In case of emergency, contact: NameRelationshipPhone (H)(V Explain "Yes" answers below. Circle questions you don't know the answers to. Yes No	v)	
Personal physician	v)	
In case of emergency, contact: NameRelationshipPhone (H)(V Explain "Yes" answers below. Circle questions you don't know the answers to. Yes No		
Name		
Explain "Yes" answers below. Circle questions you don't know the answers to. Yes No		
Explain "Yes" answers below. Circle questions you don't know the answers to. Yes No	Yes	
	Yes	
4 the state and deled a sestimated your		N
1 Has a doctor ever denied or restricted your participation in sports for any reason? 24. Do you cough, wheeze, or have difficulty breathing during or after exercise? 25. Is there anyone in your family who as asthma?		
diabetes or asthma)? 26. Have you ever used an inhaler or taken asthma medicine?		
nonprescription (over-the-counter) medications or pills? 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?		
4. Do you have any allergies to medicines, pollens, foods, or stinging insects? 28. Have you had infectious mononucleosis (mono) within the last month?		
5. Have you ever passed out or nearly passed out DURING exercise? 29. Do you have any rashes, pressure sores, or other skin problems?	ner	C
3. Have you ever passed out or nearly passed out AFTER exercise? 30. Have you had a herpes skin infection? 31. Have you ever had a head injury or concussion?		
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?		
8. Does your heart race or skip beats during exercise?		
that apply): 35. Have you ever had numbness, tingling, or High blood pressure		
☐ High cholesterol ☐ A heart infection falling? 10.Has a doctor ever ordered a test for your heart? 36. Have you ever been unable to move your arms of the control of the	or 🗇	C
(for example, ECG, echocardiogram)		
12. Does anyone in your family have a heart problem? muscle cramps or become ill? muscle cramps or become ill? 38. Has a doctor told you that you or someone in your family member or relative died of heart		
problems or of sudden death before age 50? family has sickle cell trait or sickle cell disease? A Does anyone in your family have Marfan syndrome? 39. Have you had any problems with your eyes or		
I5. Have you ever spent the night in a hospital? ☐ ☐ vision?	00	
17. Have you ever had an injury, like a sprain, muscle or 41. Do you wear protective eyewear, such as	0.46	
ligament tear, or tendinitis, that caused you to miss a goggles or a face shield? practice or game? If yes, circle affected area below: 42. Are you happy with your weight?		
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: 43. Are you trying to gain or lose weight? 44. Has anyone recommended you change your		
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, weight or eating habits? 45. Do you limit or carefully control what you eat?		
physical therapy, a brace, a cast, or crutches? If yes, circle below: 46. Do you have any concerns that you would like to discuss with a doctor?		
Head Neck Shoulder Upper arm Elbow Forearm fingers Chest FEMALES ONLY 47. Have you ever had a menstrual period?		
Upper Lower Hip Thigh Knee Shin Foot/ 48. How old were you when you had your first toes menstrual period?		
49. How many periods have you had in the last 12 months?		
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?		
allergies? I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.		