

Pre-Participation Medical Evaluation Form

Personal History

_____	_____	_____	_____
Name	Sex	Age	DOB
_____	_____	_____	_____
Grade	Sport	School	
_____	_____	_____	_____
Personal Physician	Address	Telephone	

1. Have you ever had a pre-participation physical before? Yes No
Have you ever had surgery? Yes No
2. Are you presently taking any medications or pills? Yes No
3. Do you have allergies (medicine, bees or other stinging insects?) Yes No
4. Have you ever passed out during exercise? Yes No
Have you ever been dizzy during or after exercise? Yes No
Have you ever had chest pain during or after exercise? Yes No
Do you tire more quickly than your friends during exercise? Yes No
Have you ever had high blood pressure? Yes No
Have you ever been told that you have a heart murmur? Yes No
Have you ever had a racing of your heart or skipped heartbeats? Yes No
Has anyone in your family died of heart problems or a sudden death before the age of 50? Yes No
5. Do you have any skin problems (itching, rashes, acne)? Yes No
6. Have you ever had a head injury? Yes No
Have you ever been knocked unconscious? Yes No
Have you ever had a seizure? Yes No
Have you ever had a stinger, burn or pinched nerve? Yes No
7. Have you ever had heat or muscle cramps? Yes No
Have you ever been dizzy or passed out in the heat? Yes No
8. Do you have trouble breathing or do you cough during or after activities? Yes No
9. Do you use any special equipment (pads, braces, neck role, mouth guard, eye guard)? Yes No
10. Have you had any problems with your eyes or vision? Yes No
Do you wear glasses or contacts or protective eye wear? Yes No
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling of any bones or joints?
 Head Shoulder Thigh Neck Elbow Knee Chest
 Forearm Shin/Calf Foot Back Wrist/Hand Ankle Hip

