Name _____ DOB _____ Location _____

SPORTS PHYSICAL

Please answer the following questions to the best of your ability.

	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical that could impact your sports activity?	☐	☐
2. Have you ever been hospitalized overnight?	☐	☐
Have you ever had surgery?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	☐	☐
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
4. Do you have any allergies to medicine, food, or stinging insects?	☐	☐
Do you have seasonal allergies that require treatment?	☐	☐
Have you ever had a rash or hives develop during or after exercise?	☐	☐
5. Have you ever passed out during or after exercise other than a single episode related to dehydration?	☐	☐
Have you ever been dizzy during or after exercise other than a single episode related to dehydration?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you get tired more quickly than your friends do during exercise?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Have you had high blood pressure or high cholesterol?	☐	☐
Have you ever been told you have a heart murmur?	☐	☐
Has any family member or relative died of heart problems or of sudden death before age 50 ?	☐	☐
Have you had a severe viral infection(for example, myocarditis or mononucleosis) within the last month?	☐	☐
Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
6. Do you have any current skin problems(for example, itching rashes, acne, warts, fungus, or blisters) that are not being treated?	☐	☐
7. Have you ever had a head injury or concussion?		
i.e. Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
Have you ever had a seizure?	☐	☐
Do you have frequent or severe headaches that are not being treated?	☐	☐
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
Have you ever had a stinger, burner, or pinched nerve?	☐	☐
8. Have you ever become ill from exercising in the heat?	☐	☐
9. Do you cough, wheeze, or have trouble breathing during or after activity that is not being treated?	☐	☐
Do you have asthma?	☐	☐

	Yes	No
Do you have seasonal allergies that require medical treatment?	☐	☐
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
11. Have you had any problems with your eyes or visior that have not been treated by a doctor?	☐	☐
Do you wear glasses, contacts, or protective eyewear?	☐	☐
12. Have you ever had a sprain, strain, or swelling afte injury that has not resolved or is recurring?	☐	☐
Have you broken or fractured any bones or dislocated any joints?	☐	☐
Have you had any other persisting problems with pain or swelling in muscles, tendons, bones, or joints?		

If yes to any above questions, check appropriate box and explain below.

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper arm		☐ Foot

13. Are you not happy with your weight to the point that you are taking action to gain or lose weight?	☐	☐
14. Do you feel stressed out?	☐	☐

15 FEMALES ONLY

When was your first menstrual period?

When was your most recent menstrual period?_____

How much time do you usually have from the start of one period to the start of another? _____

How many periods have you had in the last year?_____

What was the longest time between periods in the last year? _____

If you answer YES to any questions above please explain here:

_____

_____

_____

_____

Provider _____

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

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