SPORTS PRE-PARTICIPATION ASSESSMENT

www.medicine-in-motion.com

Name_____ **Date of exam** _____

Age _____ **Grade** _____ ☐ Male ☐ Female

This exam is for ☐ school (name)_____

☐ Pop Warner league sports

☐ other (e.g. camp, boxing physicals) _____

Circle the sport(s) that you will be playing:

1. Baseball
2. Basketball
3. Cheerleading
4. Cross-country
5. Field Hockey
6. Football
7. Golf
8. Gymnastics
9. Lacrosse
10. Soccer
11. Softball
12. Swimming
13. Track/Field
14. Tennis
15. Volleyball
16. Water Polo
17. Wrestling

Other _____

	Yes	No
1. Have you ever been *hospitalized (overnight)*?	☐	☐
Have you ever *had surgery?*	☐	☐
2. Are you currently *taking medication?*	☐	☐
3. Do you have any *allergies (medicines, bees)?*	☐	☐
4. Have you ever *passed out during exercise?* (not from heat)	☐	☐
Have you ever been *dizzy during exercise?* (not from heat)	☐	☐
Have you ever had *chest pain?*	☐	☐
Do you *tire more quickly* than your friends during exercise?	☐	☐
Have you ever had *high blood pressure?*	☐	☐
Have you ever been told you have a *heart murmur?*	☐	☐
Have you ever had r*acing of your heart* or *skipped beats?*	☐	☐
Has anyone in your *family died of heart problems* or a *sudden death before age 40?*	☐	☐
Does anyone in your family have *Marfan's Syndrome?*	☐	☐
5. Do you have any *skin problems* (itching, rashes, breaking out)?	☐	☐
6. Have you ever had a *head injury?*	☐	☐
Have you ever been *knocked out?*	☐	☐
Have you ever had a *seizure?*	☐	☐
Have you ever had a *burner/stinger* (pain from neck into arm)?	☐	☐
7. Have you ever had *heat cramps?*	☐	☐
Have you ever been *dizzy or passed out in the heat?*	☐	☐
8. Do you use *special pads or braces?*	☐	☐

Please explain any "yes" answers:

9. *Have you ever injured* (broken/fractured, sprained, dislocated):

☐ Hand/fingers ☐ Wrist ☐ Forearm ☐ Elbow ☐ Upper arm
☐ Shoulder ☐ Neck ☐ Chest/ribs ☐ Back ☐ Hip
☐ Thigh ☐ Knee ☐ Shin/calf ☐ Ankle ☐ Foot/toes
☐ Stress fractures?

10. *Have you ever had:*

☐ Mononucleosis ☐ Hepatitis ☐ Eye/ear injuries
☐ Diabetes ☐ Headaches (frequent) ☐ Tuberculosis
☐ Measles ☐ Asthma ☐ Stomach ulcers
☐ Hernia(s) ☐ Sickle cell trait/disease

11. When was your last *tetanus shot?* _____

12. About *your weight*: Do you think that you are ☐ just right? ☐ too heavy/fat? ☐ too light/thin?

13. Do you like to drink *milk products?* ☐ Yes ☐ No

14. For females:

When was your *first period* and how old were you? _____

When was your *last period?* _____

Are your periods ☐ regular/monthly ☐ irregular/skip months

15. Please feel free to ask the doctor to address any questions/concerns that you may have. [note: all discussions are kept confidential]

I hereby give my consent for medical evaluation and declare that the information I provided is true and correct to the best of my knowledge.

_____

Parent's signature

☐ I have reviewed above history. _____

(Physician's initials)