Save Submit

History Form for Sport Physical

Name_____ Sex Select Age_____ Grade _____Birth date _____
School_____ Sports _____
Address _____
Primary Physician _____ Emergency Contact _____

Check yes or no, please explain "yes" answers in box after 29. If you don't know the answer to a question, leave blank.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up?			18. Do you cough, wheeze or have trouble breathing during or after activity?		
2. Have you ever been hospitalized? Describe i.e., surgery?			19. Do you have asthma?		
3. Are you currently using an inhaler or taking any prescription or over-the-counter medications? If so, please list:			20. Do you use any protective or corrective equipment which isn't usually used for your sports position?		
			21. Have you had any problems with your eyes or vision? Do you wear contacts or glasses?		
4. Do you have allergies (food, drug, pollen, or insect stings)?			22. Have you ever had a sprain, strain, or swelling after an injury?		
5. Have you ever passed out or been dizzy during or after exercise?			23. Have you ever had any broken or fractured bones or dislocated joints?		
6. Have you ever had a racing heart or skipped heartbeats?			*Mark the appropriate boxes for past injury sites. Explain below* ☐ Head ☐ Elbow ☐ Hip ☐ Foot ☐ Neck ☐ Forearm ☐ Thigh ☐ Back ☐ Wrist ☐ Knee ☐ Shoulder ☐ Hand ☐ Calf ☐ Upper arm ☐ Finger ☐ Ankle		
7. Have you ever had high blood pressure or high cholesterol?					
8. Have you ever been told you have a heart murmur?					
9. Has any family member died of heart problems or of sudden death before the age of 50?					
10. Have you had any severe viral infections in the last month?			24. Do you feel stressed out?		
11. Has a physician ever denied or restricted your participation in sports?			FEMALES ONLY: 26. When was your first menstrual period?		
12. Do you have any current skin problems (such as itching, rash, warts or blisters)?			27. When was your most recent menstrual period?		
13. Have you ever had a head injury or concussion?			28. How many periods have you had in the past year?		
14. Have you ever had a seizure?			29. Are your periods regular?		
15. Do you have frequent or severe headaches?			Note Question number and explain "Yes" Answers here:		
16. Have you ever had numbness or tingling in your ☐ hands ☐ arms ☐ feet ☐ legs					
17. Have you ever become ill while exercising in the heat?					

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

_____ _____ ____/____/____
Signature of athlete Signature of parent/guardian Date