SILICON VALLEY SPORTS MED

Date of Exam: _____

Preparticipation Physical Evaluation

Name	Gender	Age	Date of Birth
Sport(s)	School		Grade
Address			Phone
Personal Physician			
Incase of Emergency, contact			
Name	Relationship		Phone

Explain the "Yes" answers below. Circle questions you do not know the answer to.

	Yes	No		Yes	No
Has a doctor ever denied or restricted your participation in sports for any reason?	O	O	Do you have an ongoing medical condition (like diabetes or asthma?	O	O
Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	O	O	Do you have allergies to medicines, pollens, foods, or stinging insects?	O	O
Have you ever passed out or nearly passed out DURING exercise?	O	O	Have you ever passed out or nearly passed out AFTER exercise?	O	O
Have you ever had discomfort, pain, or pressure in your chest during exercise?	O	O	Does your heart race or skip beats during exercise?	O	O
Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	O	O	Has anyone in your family died for no apparent reason?	O	O
Does anyone in your family have a heart problem?	O	O	Has any family member or relative died of heart problems or of sudden death before age 50?	O	O
Does anyone in your family have Marfan syndrome?	O	O	Have you ever spent the night in a hospital?	O	O
Have you ever had surgery?	O	O	Have you ever had a stress fracture?	O	O
Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	O	O	Do you regularly use a brace or assistive device?	O	O
Has a doctor ever told you that you have asthma or allergies?	O	O	Do you cough, wheeze, or have difficulty breathing during or after exercise?	O	O
Is there anyone in your family who has asthma?	O	O	Have you ever used an inhaler or taken asthma medicine?	O	O
Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	O	O	Have you had infectious mononucleosis (mono) within the last month?	O	O
Do you have any rashes, pressure sores, or other skin problems?	O	O	Have you had a herpes skin infection?	O	O
Have you ever had a head injury or concussion?	O	O	Have you been hit in the head and been confused or lost your memory?	O	O
Have you ever had a seizure?	O	O	Do you have headaches with exercise?	O	O
Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	O	O	Have you ever been unable to move your arms or legs after being hit or falling?	O	O
When exercising in the heat, do you have severe muscle cramps or become ill?	O	O	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	O	O
Have you had any problems with your eyes or vision?	O	O	Do you wear glasses or contact lenses?	O	O
Do you wear protective eyewear, such as goggles or a face shield?	O	O	Are you happy with your weight?	O	O
Are you trying to gain or lose weight?	O	O	Has anyone recommended you change your weight or eating habits?	O	O
Do you limit or carefully control what you eat?	O	O	Do you have any concerns that you would like to discuss with a doctor?	O	O

Has a doctor ever told you that you have (check all that apply):

O High blood pressure O A heart murmur O High cholesterol O A heart infection

Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis, which caused you to miss a practice or game? If yes, what area?

Yes O No O

Head	O	Neck	O	Shoulder	O	Upper Arm	O	Elbow	O	Forearm	O
Hand/Fingers	O	Chest	O	Upper Back	O	Lower back	O	Hip	O	Thigh	O
Knee	O	Ankle	O	Calf/Shin	O	Foot/Toes	O				

Have you had any broken or fractured bones, or dislocated joints? If yes, which area?

Yes O No O

Head	O	Neck	O	Shoulder	O	Upper Arm	O	Elbow	O	Forearm	O
Hand/Fingers	O	Chest	O	Upper Back	O	Lower back	O	Hip	O	Thigh	O
Knee	O	Ankle	O	Calf/Shin	O	Foot/Toes	O				

Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, which area?

Yes O No O

Head	O	Neck	O	Shoulder	O	Upper Arm	O	Elbow	O	Forearm	O
Hand/Fingers	O	Chest	O	Upper Back	O	Lower back	O	Hip	O	Thigh	O
Knee	O	Ankle	O	Calf/Shin	O	Foot/Toes	O				

Females ONLY:

Have you ever had a menstrual period? Yes O No O

How old were you when you had your first period?

How many periods have you had in the last year

Explain "Yes" Answers below:

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 _____