Sports Participation History Form

Date of Exam: _____

Name: _____ DOB: _____

Age: _____ Sex: M F

School: _____ Sport: _____

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements that you are currently taking

_____

_____

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medications Pollens Food Stinging Insects

●**Explain "Yes" answers below. Circle questions you don't know the answers to.**

GENERAL QUESTIONS	**YES**	**NO**
1. Has a doctor ever denied or restricted your participation in sports for any reason?	□	□
2. Do you have any ongoing medical conditions?	□	□
3. Have you ever spent the night in the hospital?	□	□
4. Have you ever had surgery?	□	□
HEART HEALTH QUESTIONS ABOUT YOU		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	□	□
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	□	□
7. Does your heart ever race or skip beats during exercise?	□	□
8. Has your doctor ever told you that you have any heart problems (e.g. murmur, high blood pressure)?	□	□
9. Has a doctor ever ordered a test for your heart (e.g. ECK/EKG, echocardiogram)?	□	□
10. Do you ever get lightheaded or feel more short of breath than expected during exercise?	□	□
11. Have you ever had an unexplained seizure?	□	□
12. Do you get more tired or short of breath more quickly than your friends during exercise?	□	□
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?	□	□
14. Does anyone in your family have Hypertrophic Cardiomyopathy, Marfan Syndrome, Arrhythmogenic Right Ventricular Cardiomyopathy, Long QT Syndrome, Short QT Syndrome, Brugada Syndrome or Catecholaminergic Polymorphic Ventricular Tachycardia?	□	□
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	□	□
16. Has anyone in your family had unexplained fainting, unexplained seizures or near drowning?	□	□
BONE AND JOINT QUESTIONS		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?	□	□
18. Have you ever had any broken or fractured bones or dislocated joints?	□	□
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?	□	□
20. Have you ever had a stress fracture?	□	□
21. Have you ever been told that you have or have you had an x-ray for neck or atlantoaxial instability?	□	□
22. Do you regularly use a brace, orthotics, or other assistive devices?	□	□
23. Do you have a bone, muscle, or joint injury that bothers you?	□	□
24. Do any of your joints become painful, swollen, feel warm, or look red?	□	□
25. Do you have any history of juvenile arthritis or connective tissue disease?	□	□

Medical Questions	**Yes**	**No**
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	□	□
27. Have you ever used an inhaler or taken asthma medicine?	□	□
28. Is there anyone in your family who has asthma?	□	□
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	□	□
30. Do you have groin pain or a painful bulge or hernia in the groin area?	□	□
31. Have you ever had infectious mononucleosis (mono) with the last month?	□	□
32. Do you have any rashes pressure sores, or other skin problems?	□	□
33. Have you ever had herpes or MRSA skin infections?	□	□
34. Have you ever had a head injury or a concussion?	□	□
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headaches, or memory problems?	□	□
36. Do you have a history of seizure disorder?	□	□
37. Do you have headaches with exercise?	□	□
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	□	□
39. Have you ever been unable to move your arms or legs after being hit or falling?	□	□
40. Have you ever become ill while exercising in the heat?	□	□
41. Do you get frequent muscle cramps while exercising?	□	□
42. Do you or someone in your family have sickle cell trait or disease?	□	□
43. Have you ever had any problems with your eyes or vision?	□	□
44. Have you had any eye injuries?	□	□
45. Do you wear glasses or contact lenses?	□	□
46. Do you wear protective eyewear; such as goggles or a face shield?	□	□
47. Do you worry about your weight?	□	□
48. Are you trying to or has anyone recommended that you gain or lose weight?	□	□
49. Are you on a special diet or do you avoid certain types of foods?	□	□
50. Have you ever had an eating disorder?	□	□
51. Do you have any concerns that you would like to discuss with the doctor or nurse practitioner?	□	□
FEMALES ONLY	**Yes**	**No**
52. Have you ever had a menstrual period?	□	□
53. How old were your when you had your first menstrual period?	□	□
54. How many periods have you had in the last 12 months?	□	□

Explain "yes" answers here:

_____
_____
_____
_____
_____

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

Signature of athlete _____ Date _____

Signature of parent _____ Date _____