Preparticipation Physical Evaluation
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam __________________________ Date of birth __________________________

Name __________________________ Age __________________________ Grade __________________________ School __________________________ Sport(s) __________________________

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

Do you have any allergies? □ Yes □ No
If yes, please identify specific allergy below.
□ Medicines □ Pollens □ Food □ Stinging insects

Explain "yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS

1. Has a doctor ever denied or limited your participation in sports for any reason? Yes No

2. Do you have any ongoing medical conditions? If so, please identify below: □ Asthma □ Arthritis □ Diabetes □ Infections

3. Have you ever spent the night in the hospital? □ Yes □ No

4. Have you ever had surgery? □ Yes □ No

HEART HEALTH QUESTIONS ABOUT YOU

5. Have you ever passed out or nearly passed out (fainting or aftereffects)? Yes No

6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? Yes No

7. Does your heart ever race or skip beats (irregular beats) during exercise? Yes No

8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:
□ High blood pressure □ A heart murmur □ A heart infection
□ Kawasaki disease

9. Has a doctor ever ordered a test for your heart? (For example, ECG, Echo, Cardiogram) Yes No

10. Do you get lightheaded or feel more short of breath than expected during exercise? Yes No

11. Have you ever had an unexplained syncopal episode? Yes No

12. Do you get more tired or short of breath more quickly than your friends during exercise? Yes No

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)? Yes No

14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, an inherited form of congenital heart defect, long QT syndrome, orrick syndrome, polygenic or congenital heart valve disorder? Yes No

15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? Yes No

16. Has anyone in your family had unexplained fainting, unexplained syncope, or near drowning? Yes No

NONE AND JOINT QUESTIONS

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss practice or a game? Yes No

18. Have you ever had any broken or fractured bone or displaced joint? Yes No

19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, bandage, a brace, a cast, or stitches? Yes No

20. Have you ever had a stress fracture? Yes No

21. Have you ever been told that you have or have you had an x-ray for neck instability or adverse side effects? (Down syndrome or overgrowth) Yes No

22. Do you regularly use a brace, orthosis, or other assistive device? Yes No

23. Do you have a bone, muscle, or joint injury that bothers you? Yes No

24. In any of your joints become painful, swollen, feel warm, or lock red? Yes No

25. Do you have any history of juvenile arthritis or connective tissue disease? Yes No

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 __________________________


New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71. 2-05515412
# Preparticipation Physical Evaluation

## The Athlete with Special Needs: Supplemental History Form

**Date of Exam**

**Name**

**Sex**

<table>
<thead>
<tr>
<th>Age</th>
<th>Grade</th>
<th>School</th>
<th>Sport(s)</th>
</tr>
</thead>
</table>

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

6. Do you regularly use a brace, assistive device, or prosthesis? | Yes | No |
7. Do you use any special brace or assistive device for sports? |
8. Do you have any rashes, pressure sores, or any other skin problems? |
9. Do you have a hearing loss? Do you use a hearing aid? |
10. Do you have a visual impairment? |
11. Do you use any special devices for bowel or bladder function? |
12. Do you have burning or discomfort when urinating? |
13. Have you had a runny nose or cold recently? |
14. Have you ever been diagnosed with a heart-related (hypertension) or cold-related (hypothermia) illness? |
15. Do you have muscle weakness? |
16. Do you have frequent infections that cannot be controlled by medication? |

Explain "yes" answers here

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**Please indicate if you have ever had any of the following.**

<table>
<thead>
<tr>
<th>Allergic rhinitis</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza virus</td>
<td></td>
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</tr>
<tr>
<td>Staph infection</td>
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<tr>
<td>Sore throat</td>
<td></td>
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<tr>
<td>Poor vision/night</td>
<td></td>
<td></td>
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<tr>
<td>Weakness in arms or hands</td>
<td></td>
<td></td>
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<tr>
<td>Weakness in legs or feet</td>
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<tr>
<td>Recent change in coordination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in ability to walk</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Explain "yes" answers here

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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: ____________

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