Anaheim Union H.S. District Pre-Participation Physical Evaluation

Name_____Sex_____Age_____Date of birth_____

Grade_____School_____Sport(s)_____

History - Explain "Yes" answers below. Circle questions you don't know the answers to.

1. Has a doctor ever denied or restricted your participation in sports for any reason?	Yes	No
2. Do you have an ongoing medical condition (like diabetes or asthma)?	Yes	No
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills?	Yes	No
4. Do you have any allergies to medicines, pollens, foods, or stinging insects?	Yes	No
5. Have you ever passed out or nearly passed out DURING exercise?	Yes	No
6. Have you ever passed out or nearly passed out AFTER exercise?	Yes	No
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	Yes	No
8. Does your heart race or skip beats during exercise?	Yes	No
9. Has a doctor ever told you that you have (check all that apply): High blood pressure, Heart murmur, High cholesterol, Heart infection	Yes	No
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	Yes	No
11. Has anyone in your family died for no apparent reason?	Yes	No
12. Does anyone in your family have a heart problem?	Yes	No
13. Has any family member or relative died of heart problems or of sudden death before age 50?	Yes	No
14. Does anyone in your family have Marfan syndrome?	Yes	No
15. Have you ever spent the night in a hospital?	Yes	No
16. Have you ever had surgery?	Yes	No
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	Yes	No
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	Yes	No
19. Have you had a bone or joint injury that required xrays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	Yes	No
Head, Neck, Shoulder, Upper Arm, Elbow, Forearm, Hand/Fingers, Chest, Upper Back, Lower Back, Hip, Thigh, Knee, Calf/Shin, Ankle, Foot/Toes		
20. Have you ever had a stress fracture?	Yes	No

21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	Yes	No
22. Do you regularly use a brace or assistive device?	Yes	No
23. Has a doctor ever told you that you have asthma or allergies?	Yes	No
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	Yes	No
25. Is there anyone in your family who as asthma?	Yes	No
26. Have you ever used an inhaler or taken asthma medicine?	Yes	No
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	Yes	No
28. Have you had infectious mononucleosis (mono) within the last month?	Yes	No
29. Do you have any rashes, pressure sores, or other skin problems?	Yes	No
30. Have you had a herpes skin infection?	Yes	No
31. Have you ever had a head injury or concussion?	Yes	No
32. Have you been hit in the head and been confused or lost your memory?	Yes	No
33. Have you ever had a seizure?	Yes	No
34. Do you have headaches with exercise?	Yes	No
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	Yes	No
36. Have you ever been unable to move your arms or legs after being hit or falling?	Yes	No
37. When exercising in the heat, do you have severe muscle cramps or become ill?	Yes	No
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	Yes	No
39. Have you had any problems with your eyes or vision?	Yes	No
40. Do you wear glasses or contact lenses?	Yes	No
41. Do you wear protective eyewear, such as goggles or a face shield?	Yes	No
42. Are you happy with your weight?	Yes	No
43. Are you trying to gain or lose weight?	Yes	No
44. Has anyone recommended you change your weight or eating habits?	Yes	No
45. Do you limit or carefully control what you eat?	Yes	No
46. Do you have any concerns that you would like to discuss with a doctor?	Yes	No
FEMALES ONLY		
47. Have you ever had a menstrual period?	Yes	No
48. How old were you when you had your first menstrual period?		
49. 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_____**Signature of parent/guardian**_____**Date**_____

PHYSICIAN PHYSICAL EVALUATION

Height_____Weight_____% Body fat (optional)_____Pulse_____BP____/_____ (_____/_____ ,_____/_____)

Vision R 20/ ____ L 20/ ____ Corrected: Y N Pupils: Equal _____ Unequal _____

◯ Cleared ◯ Cleared after completing evaluation/rehabilitation for:_____

◯ Not cleared for:_____ Reason:_____

Name of physician (print/type) _____ **Date of Physical** _____

Doctor's Address/Phone – Any doctor's stamp MUST INCLUDE DOCTOR'S NAME _____

Signature of physician_____ ◯**MD** or ◯**DO** License #_____**Physical MUST be signed by MD or DO – not PAC, RNP, DC, etc.**