



# ATHLETIC DEPARTMENT

## Preparticipation Evaluation



Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Phone \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Fill in details of "YES" answers in space below.

|  | YES        | NO    |
|--|------------|-------|
| 1. Have you ever been hospitalized?  | _____      | _____ |
| Have you ever had surgery?   | _____      | _____ |
| 2. Are you currently taking any medication?  | _____      | _____ |
| 3. Do you have any allergies, (medicine, bees)?                                      | _____      | _____ |
| 4. Do you ever pass out during exercise?   | _____      | _____ |
| Have you ever been dizzy during exercise?  | _____      | _____ |
| Have you ever had chest pain?  | _____      | _____ |
| Do you tire more quickly than your friends during exercise?                          | _____      | _____ |
| Have you ever had high blood pressure?   | _____      | _____ |
| Have you ever been told you have a heart murmur?                                     | _____      | _____ |
| Have you ever had racing of your heart or skipped beats?                             | _____      | _____ |
| Has anyone in your family died of heart problems or a sudden death before age 40?    | _____      | _____ |
| 5. Do you have any skin problems, (itching, moles, breaking out?)                    | _____      | _____ |
| 6. Have you ever had a head injury?  | _____      | _____ |
| Have you ever been knocked out?  | _____      | _____ |
| Have you ever had a seizure?   | _____      | _____ |
| Have you ever had a stinger or burner?   | _____      | _____ |
| 7. Have you ever injured, (sprained, dislocated, fractured, etc.):                   |            |       |
| _____ Hand      _____ Shoulder      _____ Thigh      _____ Arm      _____ Elbow      |            |       |
| _____ Wrist      _____ Neck      _____ Knee      _____ Hip      _____ Back           |            |       |
| _____ Forearm      _____ Chest      _____ Shin/calf      _____ Foot      _____ Ankle |            |       |
| 8. Have you ever had heat cramps?  | _____      | _____ |
| Have you ever been dizzy or passed out in the heat?                                  | _____      | _____ |
| 9. Have you ever had:  |            |       |
| _____ Mononucleosis      _____ Diabetes      _____ Tuberculosis                      |            |       |
| _____ Hepatitis      _____ Headaches(frequent)      _____ Stomach Ulcer              |            |       |
| _____ Asthma      _____ Eye Injuries   |            |       |
| 10. Do you use special pads or braces?   | _____      | _____ |
| 11. When was your last tetanus shot?   | Date _____ |       |
| 12. When was your first period?  | _____      |       |
| When was your last period?   | Date _____ |       |

Explain "YES" answers here:

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If minor, Parent's signature: \_\_\_\_\_

**Bring this completed form with you to your examination.**

