

# South River Pediatrics Sports Physical Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Sport: \_\_\_\_\_

Patients Signature: \_\_\_\_\_ Parents Signature: \_\_\_\_\_

Please answer all questions. If you circle "YES", please use all the back or bottom to give dates and specifics. Thank You!

1. Have you ever:

- A. Been a patient overnight in the hospital? Y N
- B. Been a patient in an emergency room? Y N
- C. Had an injury that required x-ray? Y N
- D. Had an operation? Y N
- E. Had an injury that required you to miss a game or practice? N Y
- F. Had an injury that required a doctor's care? N Y

2. Are you now under the care of a physician for illness, injury or problem? N Y

3. Do you have any injuries at this time? Y N

4. Are you taking any medicines, either prescription or over the counter? N Y

5. Have you ever had?

- A. A broken bone? Y N
- B. A torn ligament? Y N
- C. A muscle pull? Y N
- D. A pinched nerve? Y N
- E. A neck or head injury? Y N
- F. A back injury or back problem? Y N

6. Have any members of your family under age 50 had a "heart attack" or a "heart problem" or died suddenly from a "heart problem"? Y N

7. Have you ever been told that you have heart murmur, high blood pressure, an extra heart beat or a heart abnormality? Y N

8. Have you ever felt your heart was "beating funny" or that your heart "skipped" a beat? Y N

9. Have you ever passed out or been knocked out? Y N

10. Do you have to stop while running around a quarter mile track twice? Y N

11. Do you have any shortness of breath or chest tightness when exercising? Y N

12. Do you cough or wheeze with exercise? Y N

13. Have you ever had?

- A. Asthma or wheezing? Y N
- B. Seizures? Y N
- C. Allergies, hay fever, hives, or reaction to insect or bee stings? Y N
- D. A hernia? Y N

14. If you are a boy:

- A. do you have both testicles? Y N
- B. Have you ever had an injury to or an operation on your testicles? Y N

15. If you are a girl:

- A. Have you started your menstrual cycle? Y N
- B. If so, age started\_\_\_\_, # of days between cycle\_\_\_\_, # of days of flow\_\_\_\_\_.
- C. Do you skip cycles? Y N
- D. Do you have spotting or bleeding between cycles? Y N
- E. Date of beginning of last menstrual cycle?\_\_\_\_\_.

16. Do you wear glasses or contact lenses? Y N

17. Do you have braces, "capped teeth" or other dental work in your mouth? Y N

18. Do you have any skin conditions such as boils, impetigo, scabies, or herpes? Y N