

SPORT 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 a 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? Y N
 - f. had an injury that required a doctors care? Y N
2. Are you now under the care of a physician for any illness, injury or problem? Y N
3. Do you have any injuries at the this time? Y N
4. Are you taking any medicines, either prescription or over the counter? Y N
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 a heart murmur, high blood pressure, an extra heart beat or a heart abnormality? Y N
8. Have you ever felt that 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