

SACRED HEART HIGH SCHOOL
PRE-PARTICIPATION PHYSICAL EVALUATION
HEALTH HISTORY QUESTIONNAIRE

(PLEASE PRINT)

Date _____

Name _____ Date of Last Physical _____ Age _____
 Date of Birth _____ School _____ Sex _____
 Sport _____ Home Phone _____ Grade _____
 Physician _____ Phone _____ FAX _____

Emergency Contact Information:

Name _____ Relationship _____ Phone _____

Directions Please answer the following questions about your medical history. (PLEASE PRINT)
 Explain "yes" answers at the bottom of the page. You must respond to all questions.

1. Have you had or do you currently have:

a. A sports physical for this school?	Yes	No	Don't Know
b. An injury or illness since your last exam?	Yes	No	Don't Know
c. A chronic or ongoing illness (such as diabetes or asthma)?	Yes	No	Don't Know
1. use an inhaler or other prescription medicine to control asthma?	Yes	No	Don't Know
d. Any prescribed or over-the-counter medications that you take on a regular basis?	Yes	No	Don't Know
e. Surgery, hospitalization or any emergency room visit(s)?	Yes	No	Don't Know
f. Any allergies to medications?	Yes	No	Don't Know
g.. Any allergies to bee stings, pollen, latex or foods?	Yes	No	Don't Know
1. Type of reaction: rash, hives, or skin condition?	Yes	No	Don't Know
2. Take any medication/epipen taken for allergy symptoms? (List below)	Yes	No	Don't Know
h. Any anemias or blood disorders?	Yes	No	Don't Know

2. Have you had or do you currently have any of the following **head-related** conditions since your last physical:

a. Concussion requiring a physician's evaluation?	Yes	No	Don't Know
1. how often and when? (Answer below)			
b. Memory loss or been knocked out?	Yes	No	Don't Know
c. A seizure?	Yes	No	Don't Know
d. Frequent or severe headaches?	Yes	No	Don't Know

3. Have you had or do you currently have any of the following **heart-related** conditions since your last physical?

a. Chest pain? (When exercising?)	Yes	No	Don't Know
b. Heart murmur?	Yes	No	Don't Know
c. High blood pressure or elevated cholesterol level?	Yes	No	Don't Know
d. Restriction from sports for heart problems?	Yes	No	Don't Know
e. Any family member or relative:			
1. Died of a heart problem before age 35?	Yes	No	Don't Know
2. Died of a heart problem before age 50?	Yes	No	Don't Know
3. Died with no known reason?	Yes	No	Don't Know
4. Died while exercising? During or after?	Yes	No	Don't Know
5. Marfan's Syndrome?	Yes	No	Don't Know

Explain "Yes" answers here (include dates):

4. Have you had or do you currently have any of the following **eye, ear, nose, mouth, or throat** conditions since your last physical:
- a. Vision problems? Yes No Don't Know
 - 1. Wear contacts, eyeglasses or protective eye wear? (Circle which type) Yes No Don't Know
 - b. Hearing loss or problems? Yes No Don't Know
 - 1. Wear hearing aides or implants? Yes No Don't Know
 - c. Nasal fractures or frequent nose bleeds? Yes No Don't Know
 - d. Wear braces, retainer or protective mouth gear? Yes No Don't Know
 - e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? Yes No Don't Know
5. Have you had or do you currently have any of the following **neuromuscular/orthopedic conditions** since your last physical?
- a. Been told you had a burner, stinger, or pinched nerve? Yes No Don't Know
 - b. A sprain? Yes No Don't Know
 - c. A strain? Yes No Don't Know
 - d. Swelling or pain in muscles, tendons, bones or joints? Yes No Don't Know
 - e. A dislocated joint(s)? Yes No Don't Know
 - f. Low back pain? Yes No Don't Know
 - g. Fracture(s) or stress fracture(s)? Yes No Don't Know
 - h. Do you wear any protective braces or equipment for any prior injury? Yes No Don't Know
6. Have you had or do you currently have any of the following **general or exercise related conditions** since your last physical?
- a. Difficulty breathing? (During exercise) Yes No Don't Know
 - 1. After running 1 mile? Yes No Don't Know
 - 2. Coughing, wheezing or shortness of breath in weather changes? Yes No Don't Know
 - 3. Been told you have exercise-induced asthma? Yes No Don't Know
 - i. Controlled with medication? (List below) Yes No Don't Know
 - ii. Experienced dizziness, passing out or fainting? Yes No Don't Know
 - b. Viral infections (e.g. mono, hepatitis)? Yes No Don't Know
 - c. Become tired more quickly than your friends? Yes No Don't Know
 - d. Any of the following skin conditions: Yes No Don't Know
 - 1. Acne, contact dermatitis, ringworm, warts, herpes? Yes No Don't Know
 - 2. Sun sensitivity Yes No Don't Know
 - e. Weight gain/loss (greater than or less than 10 pounds)? Yes No Don't Know
 - 1. Do you want to weigh more or less than you do now? Yes No Don't Know
 - f. Ever had feelings of depression? Yes No Don't Know
 - g. Heat-related problems (dehydration, dizziness, fatigue, headache)? Yes No Don't Know
 - 1. Heat exhaustion? (cool, clammy, damp skin)? Yes No Don't Know
 - 2. Heat stroke? (hot, red, dry skin)? Yes No Don't Know

Explain "Yes" answers here (include dates):

I (give my consent and approval to the participation of my son/daughter in the interscholastic athletic program at Sacred Heart High School. I am aware and acknowledge that physical hazards, resulting in body injury and even death, may be encountered during his/her participation. I will not hold Sacred Heart High School, agencies cooperating with Sacred Heart High School administration staff, or the coaching staff responsible in case of accident or injury, as a result of his/her participation. I certify that the information provided herein is accurate as of the date of these signatures.

Parent/Guardian Signature

Date