Brighton Pediatric Center

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Pre-Participation Physical Evaluation

Patient's Name:_____*Date of Birth*:_____ *Age*:_____

The student or parent should complete this questionnaire. Please explain "yes" answers where indicated. If you are not sure of an answer, circle the question for follow up. Thank you.

	Yes	No
1. Have you had a medical illness or injury since your last check-up or sports physical?	☐	☐
If yes, please explain: _____		
2. Do you have an ongoing chronic illness?	☐	☐
If yes, please explain: _____		
3. Have you ever been hospitalized overnight?	☐	☐
If yes, please explain: _____		
4. Have you ever had surgery?	☐	☐
If yes, please explain: _____		
5. Are you currently taking any prescription or nonprescription (over-the-counter) medications/ pills or using an inhaler?	☐	☐
If yes, please explain:_____		
6. Have you ever taken any supplements or vitamins to help you gain/ lose weight or improve your performance?	☐	☐
If yes, please explain: _____		
7. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?	☐	☐
If yes, please explain: _____		
8. Have you ever had a rash or hives develop during or after exercise?	☐	☐
If yes, please explain: _____		
9. Have you ever passed out during or after exercise?	☐	☐
If yes, please explain:_____		
10. Have you ever been dizzy during or after exercise?	☐	☐
If yes, please explain:_____		
11. Have you ever had chest pain during or after exercise?	☐	☐
If yes, please explain:_____		
12. Do you get tired more quickly than your friends do during exercise?	☐	☐
If yes, please explain:_____		
13. Have you ever had racing of your heart or skipped heartbeats?	☐	☐
If yes, please explain:_____		
14. Have you had high blood pressure or high cholesterol?	☐	☐
If yes, please explain:_____		
15. Have you ever been told you have a heart murmur?	☐	☐
If yes, please explain:_____		
16. Has any family member or relative died of heart problems or sudden death before age 50?	☐	☐
If yes, please explain:_____		
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
If yes, please explain:_____		
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
If yes, please explain:_____		
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	☐	☐
If yes, please explain:_____		
20. Have you ever had a head injury or concussion?	☐	☐
If yes, please explain:_____		
21. Have you ever been knocked out, become unconscious or lost your memory?	☐	☐
If yes, please explain:_____		
22. Have you ever had a seizure?	☐	☐
If yes, please explain:_____		

Pre-Participation Physical Evaluation

	Yes	No
23. Do you have frequent or severe headaches?	☐	☐
If yes, please explain:_____		
24. Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
If yes, please explain:_____		
25. Have you ever had a stinger, burner or pinched nerve?	☐	☐
If yes, please explain:_____		
26. Have you ever become ill from exercising in the heat?	☐	☐
If yes, please explain:_____		
27. Do you cough, wheeze or have trouble breathing during or after activity?	☐	☐
If yes, please explain:_____		
28. Do you have asthma?	☐	☐
If yes, please explain:_____		
29. Do you have seasonal allergies that require medical treatment?	☐	☐
If yes, please explain: _____		
30. Do you use any special protective or corrective equipment/ devices that aren't usually used for your sport or position, (for example, knee brace, special neck roll, foot orthotics, retainer for your teeth, hearing aid)?	☐	☐
If yes, please explain:_____		
31. Have you had any problems with your eyes or vision?	☐	☐
If yes, please explain:_____		
32. Do you wear glasses, contacts or protective eyewear?	☐	☐
If yes, please explain:_____		
33. Have you ever had a sprain, strain or swelling after injury?	☐	☐
If yes, please explain:_____		
34. Have you broken or fractured any bones or dislocated any joints?	☐	☐
If yes, please explain:_____		
35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	☐	☐
Please check all that apply, and explain where indicated:		
Head Elbow Hip Neck Forearm Thigh Back Wrist Knee		
Chest Hand Shin/Calf Shoulder Finger Ankle Upper Arm Foot		
If yes, please explain:_____		
36. Do you want to weigh more or less than you do now?	☐	☐
If yes, please explain:_____		
37. Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
If yes, please explain:_____		
38. Do you feel stressed out?	☐	☐
If yes, please explain:_____		
39. Have you ever had Chickenpox?	☐	☐
When?_____		

FEMALES ONLY – *Optional* –

40. When was your first menstrual period?_____

41. When was your most recent menstrual period?_____

42. How much time do you usually have from the start of one period to the start of another?_____

_____

43. How many periods have you had in the last year?_____

44. What was the longest time between periods in the last year?_____

45. Other concerns_____

_____ _____/_____/_____

Signature of parent/guardian/student ***Date***