

New Jersey Department of Education ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

Part A: HEALTH HISTORY QUESTIONNAIRE-Completed by the parent and student and reviewed by examining provider
Part B: PHYSICAL EVALUATION FORM-Completed by examining licensed provider with MD, DO, APN or PA

Part A: HEALTH HISTORY QUESTIONNAIRE

Today's Date: _____ Date of Last Sports Physical: _____

Student's Name: _____ Sex: M F (circle one) Age: _____ Grade: _____

Date of Birth: ___/___/___ School: _____ District: _____

Sport(s): _____ Home Phone: (____) _____

Provider Name (Medical Home): _____ Phone: _____ Fax: _____

EMERGENCY CONTACT INFORMATION

Name of parent/guardian: _____ Relationship to student: _____

Phone (work): _____ Phone (home): _____ Phone (cell): _____

Additional emergency contact: _____ Relationship to student: _____

Phone (work): _____ Phone (home): _____ Phone (cell): _____

Directions: Please answer the following questions about the student's medical history by **CIRCLING** the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

1. Have you ever had, or do you currently have:

- | | |
|--|---------------------------|
| a. Restriction from sports for a health related problem? | Y / N / Don't Know |
| b. An injury or illness since your last exam? | Y / N / Don't Know |
| c. A chronic or ongoing illness (such as diabetes or asthma)? | Y / N / Don't Know |
| (1.) An inhaler or other prescription medicine to control asthma? | Y / N / Don't Know |
| d. Any prescribed or over the counter medications that you take on a regular basis? | Y / N / Don't Know |
| e. Surgery, hospitalization or any emergency room visit(s)? | Y / N / Don't Know |
| f. Any allergies to medications? | Y / N / Don't Know |
| g. Any allergies to bee stings, pollen, latex or foods? | Y / N / Don't Know |
| (1.) If yes, check type of reaction: | |
| <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Breathing or other anaphylactic reaction | |
| (2.) Take any medication/Epipen taken for allergy symptoms? (List below.) | Y / N / Don't Know |
| h. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders? | Y / N / Don't Know |
| i. A blood relative who died before age 50? | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

List all medications here:

Medication Name	Dosage	Frequency

2. **Have you ever had, or do you currently have, any of the following *head-related* conditions:**

- a. Concussion or head injury (including "bell rung" or a "ding")? Y / N / Don't Know
- b. Memory loss? Y / N / Don't Know
- c. Knocked out? Y / N / Don't Know
- c. A seizure? Y / N / Don't Know
- d. Frequent or severe headaches (With or without exercise)? Y / N / Don't Know
- e. Fuzzy or blurry vision Y / N / Don't Know
- f. Sensitivity to light/noise Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

3. **Have you ever had, or do you currently have, any of the following *heart-related* conditions:**

- a. Restriction from sports for heart problems? Y / N / Don't Know
- b. Chest pain or discomfort? Y / N / Don't Know
- c. Heart murmur? Y / N / Don't Know
- d. High blood pressure? Y / N / Don't Know
- e. Elevated cholesterol level? Y / N / Don't Know
- f. Heart infection? Y / N / Don't Know
- g. Dizziness or passing out during or after exercise without known cause? Y / N / Don't Know
- h. Has a provider ever ordered a heart test (EKG, echocardiogram, stress test, Holter monitor)? Y / N / Don't Know
- i. Racing or skipped heartbeats? Y / N / Don't Know
- j. Unexplained difficulty breathing or fatigue during exercise? Y / N / Don't Know
- k. Any family member (blood relative):
 - (1.) Under age 50 with a heart condition? Y / N / Don't Know
 - (2.) With Marfan Syndrome? Y / N / Don't Know
 - (3.) Died of a heart problem before age 50? If yes, at what age? _____ Y / N / Don't Know
 - (4.) Died with no known reason? Y / N / Don't Know
 - (5.) Died while exercising? If yes, was it during or after? (Circle one.) Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

4. **Have you ever had, or do you currently have, any of the following *eye, ear, nose, mouth or throat* conditions:**

- a. Vision problems?
 - (1.) Wear contacts, eyeglasses or protective eye wear? (Circle which type.) Y / N / Don't Know
- b. Hearing loss or problems?
 - (1.) Wear hearing aides or implants? Y / N / Don't Know
- c. Nasal fractures or frequent nose bleeds? Y / N / Don't Know
- d. Wear braces, retainer or protective mouth gear? Y / N / Don't Know
- e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

5. **Have you ever had, or do you currently have, any of the following *neuromuscular/orthopedic* conditions:**

- a. Numbness, a "burner", "stinger" or pinched nerve? Y / N / Don't Know
- b. A sprain? Y / N / Don't Know
- c. A strain? Y / N / Don't Know
- d. Swelling or pain in muscles, tendons, bones or joints? Y / N / Don't Know
- e. Dislocated joint(s)? Y / N / Don't Know
- f. Upper or lower back pain? Y / N / Don't Know
- g. Fracture(s), stress fracture(s), or broken bone(s)? Y / N / Don't Know
- h. Do you wear any protective braces or equipment? Y / N / Don't Know

Explain all (yes) answers here (include relevant dates):

6. Have you ever had or do you currently have any of the following *general or exercise related conditions*:

- a. Difficulty breathing?
 - (1.) During exercise? Y / N / Don't Know
 - (2.) After running one mile? Y / N / Don't Know
 - (3.) Coughing, wheezing or shortness of breath in weather changes? Y / N / Don't Know
 - (4.) Exercise-induced asthma? Y / N / Don't Know
 - i. Controlled with medication? (specify _____) Y / N / Don't Know
 - ii. Experience dizziness, passing out or fainting? Y / N / Don't Know
- b. Viral infections (e.g. mono, hepatitis, coxsackie virus)? Y / N / Don't Know
- c. Become tired more quickly than others? Y / N / Don't Know
- d. Any of the following skin conditions:
 - (1.) Cold sores/herpes, impetigo, MRSA, ringworm, warts? Y / N / Don't Know
 - (2.) Sun sensitivity? Y / N / Don't Know
- e. Weight gain/loss (of 10 pounds or more)?
 - (1.) Do you want to weigh more or less than you do now? Y / N / Don't Know
- f. Ever had feelings of depression? Y / N / Don't Know
- g. Heat-related problems (dehydration, dizziness, fatigue, headache)?
 - (1.) Heat exhaustion (cool, clammy, damp skin)? Y / N / Don't Know
 - (2.) Heat stroke (hot, red, dry skin)? Y / N / Don't Know
 - (3.) Muscle cramps? Y / N / Don't Know
- h. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

7. **Females only:**

Age of onset of menstruation: _____ How many menstrual periods in the last twelve (12) months? _____
How many periods missed in the last twelve (12) months? _____

8. **Males only:**

Have you had any swelling or pain in your testicles or groin? Y / N / Don't Know

PARENT/GUARDIAN SIGNATURE

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

Signature, Parent/Guardian or Student Age 18

Date of Signature:

THIS COMPLETED AND SIGNED HEALTH HISTORY MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAM.