



JJC Wolves Pre-participation Physical Evaluation



Date of Exam _____

Name _____ Sex _____ Age _____ Date of Birth _____
Grade _____ School _____ Sport(s) _____
Address _____ Home Phone _____ Cell Phone _____
Personal Physician _____ Emergency Contact _____
Relationship _____ Phone (H) _____ (W) _____

Circle questions you do not know the answer to.

- 1. Has a doctor ever restricted your participation in sports?
2. Do you have an ongoing medical condition?
3. Are you currently taking any prescription or over-the-counter medicines, pills, vitamins or supplements?
4. Do you have allergies to any medicines, pollens or stinging insects?
5. Have you ever passes out DURING exercise?
6. Have you ever passed out AFTER exercise?
7. Do you have , or have you ever had chest discomfort?
8. Does you heart race or skip a beat during exercise?
9. Has a doctor ever told you have:
10. Has a doctor ever ordered a test for your heart?
11. Has anyone in your family died for no apparent reason?
12. Has any family member died of a heart problem or of sudden death before age 50?
13. Does anyone in your family have Marfan's syndrome?
14. Have you ever spent the night in a hospital?
15. Have you ever had surgery?
16. Have you ever had a stress fracture?
17. Have you been told that you have or have you had an x/ray for atlantoaxial (neck) instability?
18. Do you regularly use a brace or assistive device?
19. Has a doctor ever told you that you have asthma?
20. Do you cough, wheeze, of have difficulty breathing DURING or AFTER exercise?
21. Have you ever used an inhaler or taken asthma medications?
22. Were you born without or are you missing a kidney, eye, testicle, or any other organ?
23. Have you had infectious mononucleosis (mono) within the last month?
24. Do you have any rashes, pressure sores, herpes skin infections, or other skin problem?
25. Have you had a head injury, concussion, or ever been knocked out?
26. Have you been hit in the head and been
27. Have you ever had a seizure?
28. Do you have headaches WITH exercise?
29. Have you ever had numbness, tingling, or Weakness in your arms or legs AFTER being hit or falling?
30. Have you ever been unable to move your arms or legs AFTER being hit or falling?
31. When exercising in the heat, do you have severe muscle cramps or become ill?
32. Has a doctor told you that you or someone in your family has sickle cell disease or trait?
33. Have you had any eye or vision problems?
34. Do you wear glasses or contacts?
35. Do you wear protective eyewear for sports?
36. Are you happy with your weight?
37. Are you trying to lose weight?
38. Has anyone recommended you change your weight or eating habits?
39. Do you limit carefully what you eat?
40. Have you ever had a heat related injury?
41. Do you feel you take unnecessary risks?
42. In the past 12 months have you received a speeding ticket?
43. Do you lose (cut) weight regularly for your sport?
44. Have you ever had an injury, sprain, muscle or ligament tear, or tendonitis that caused you to miss practice or a game? If yes, mark off below.
45. Have you ever had a broken bone or dislocated joint? If yes, mark off below.
46. Have you ever had a menstrual period?
47. Are your periods regular?
48. Are you, or have you ever been told you were anemic?
49. Do you have, or have you ever been told you you have low iron?

HISTORY FORM



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Have you had an bone or joint injury that has required x-rays, MRI, CT, surgery, injections, physical therapy, a brace or crutches? If yes please explain what happened as well as when it occurred and how it was treated.

Yes	No	Body Part	Explanation
		<u>Head</u>	
		<u>Arms</u>	
		<u>Chest</u>	
		<u>Thighs</u>	
		<u>Ankles</u>	
		<u>Neck</u> -	
		<u>Elbows</u>	
		<u>Back</u>	
		<u>Knees</u>	
		<u>Feet/Toes</u>	
		<u>Shoulders</u>	
		<u>Hands/Fingers</u>	
		<u>Hips</u>	
		<u>Calves/Shins</u>	