Yellow

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 Age: ____ Grade: _____ Home Phone # __________________

Date of Birth: ____/___/_______School: ❑ ____ District: ___________________________

Sport (s): ____

Provider's Name (Medical Home): ____________________________________ Phone: _____________________ Fax: ______________

Emergency Contact Information

Mother/Guardian's
Name: ________________________________
Cell # Work#

Father's/Guardian's
Name: ________________________________
Cell # Work#

Additional Emergency Contact: Relationship to Student: Cell # Home#

Health History Information

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 each section. **Respond to all questions.**

1. Have you ever had, or do you currently have:	Y / N / Don't Know
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:	Y / N / Don't Know
❑ Rash ❑ Hives ❑Breathing or other anaphylactic reaction	
(2.) Take any medication/Epi-pen 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):	

MEDICATIONS: List all medications here:

Medication Name:	Rationale 0r Indication:	Dosage	Frequency/Times Given

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
d. A seizure(s)?	Y / N / Don't Know
e. Frequent or severe headaches (With or without exercise)?	Y / N / Don't Know
f. Fuzzy or blurry vision	Y / N / Don't Know
g. 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 currently have, any of the following *EYE, EAR, NOSE, MOUTH or THROAT conditions*:	
a. Vision problems?	Y / N / Don't Know
(1). Wear contacts, eyeglasses or protective eye wear? (Circle which type.)	Y / N / Don't Know
b. Hearing loss or problems?	Y / N / Don't Know
(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?	Y / N / Don't Know
(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:	Y / N / Don't Know
(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)?	Y / N / Don't Know
(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)?	Y / N / Don't Know
(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: a. Age of onset of menstruation:____________________	
b. How many menstrual periods in the last twelve (12) months? ________________________	
8. Males only:	
a. 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.

Printed Parent Name:____ Signature date: _________________

Parent/ Guardian or Student Age 18+ Signature: ____

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