

# 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:
        - Rash  Hives  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
  - d. A seizure? 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
  - f. Sensitivity to light/noise Y / N / Don't Know

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

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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):

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4. Have you ever had, or do you 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):

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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):

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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)?                                     | 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):

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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

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**PARENT/GUARDIAN SIGNATURE**

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I give my consent and approval for 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, the administration, staff, or 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 to the best of my knowledge as of the date of my signature.

\_\_\_\_\_  
 Signature, Parent/Guardian

\_\_\_\_\_  
 Date of Signature

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