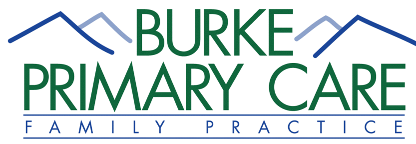

Burke Primary Care
Sports Participation History Form

Name:____ Sex:_____ Age:_____ DOB:____________________

Grade:_________ School:__________________________ Sports:_____________________________________

Address:____

Personal Physician:____

Explain "Yes" answers below. Circle questions you don't know the answer to.

1. Have you had a medical illness or injury since your last check or sports physical?
2. Have you ever been hospitalized overnight?
3. Have you ever had surgery
4. Are you currently using an inhaler or taking any prescription or nonprescription (over-the-counter) medication or pills?
5. Have you ever taken supplements or vitamins to help you gain or lose weight to improve your performance?
6. Do you have allergies (for ex., to pollen, medicine, food, or stinging insects)?
7. Have you ever had a rash or hives develop during or after exercise?
8. Have you ever passed out during or after exercise?
9. Have you ever been dizzy during or after exercise?
10. Have you ever had chest pain during or after exercise?
11. Do you get tired more quickly than your friends do during exercise?
12. Have you ever had racing of your heart or skipped heartbeats?
13. Have you had high blood pressure or high cholesterol?
14. Have you ever been told you have a heart murmur?
15. Has any family member or relative died of heart problems or of sudden death before age 50?
16. Have you had a severe viral infection (for ex., myocarditis, or mononucleosis) within the last month?
17. Has a physician ever denied or restricted your participation in sports for any heart problem?
18. Do you have any current skin problems (for ex., itching, rashes, acne, warts, fungus, or blisters)?
19. Have you ever had a head injury or concussion?
20. Have you ever been knocked out, become unconscious, or lost your memory?
21. Have you ever had a seizure?
22. Do you have a frequent or severe headaches?
23. Have you ever had numbness or tingling in your arms, hands, legs, or feet?
24. Have you ever had a stinger, burner, or pinched nerve?
25. Have you ever become ill from exercising in the heat?
26. Do you cough, wheeze or have trouble breathing during or after activity?
27. Do you have asthma?
28. Do you have any seasonal allergies that require medical treatment?
29. Do you use any special protective or corrective equipment of devices that aren't usually used for your sport or position (for ex., knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?
30. Have you had any problems with your eyes or vision?
31. Do you wear glasses, contacts, or protective eyewear?
32. Have you ever had a sprain, strain, or swelling after injury?
33. Have you ever broken or fractured any bones or dislocated any joints?
34. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints in the following areas:

Head	Elbow	Hip
Neck	Forearm	Thigh
Back	Wrist	Knee
Chest	Hand	Shin/calf
Shoulder	Finger	Ankle
Upper Arm		Foot

35. Do you want to weigh more or less than you do now?
36. Do you feel stressed out?
37. Record the dates of your most recent immunizations (shots) for:

Tetanus:________________ Measles:___________________

Hepatitis B:________________ Chickenpox:________________

FEMALES ONLY

38. When was your first menstrual period? __________________________
39. When was your most recent menstrual period? ___________________
40. How much time do you usually have from the start of one period to the start of another? ____
41. How many periods have you had in the last year? _________________
42. What was the longest time between periods in the last year? _________

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

_______________________________ _______________________________ _______________

Signature of Athlete Signature of Parent/Gaurdian Date