

Marygrove College

Pre-participation Physical Examination Health History Form

Student's Last Name: _____	First Name: _____
Date of Birth: _____	Sex: _____ Age: _____
Place of Birth: _____	
Student's Address: _____	
City: _____ Zip: _____ Phone: _____	
Parent(s) or Guardian(s) Name: _____	
Family Physician's Name: _____	

HEALTH HISTORY – This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before participation in interscholastic athletics in order to help detect possible risks. **Must be completed before physical examination.**

Explain "YES" answers below. Circle questions you do not know the answer to.

Student's Signature		Date			
1. Have you had a medical illness since your last checkup or sports physical?	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
2. Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
4. <i>Do you think you are in good health?</i>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any allergies? (Food, pollen, medicine, or insect stings?)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy before or during exercise?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pains before or during exercise?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Have you had high blood pressure or cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Is there a family history of heart problems in a close relative younger than age 50 (examples are enlarged heart, cardiomyopathy, long QT interval, abnormal EKG, abnormal heart rhythm)?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Have you had a severe heart infection (for example myocarditis or pericarditis)?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Is there a family history of Marfan's Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Has a physician ever denied or restricted your participation in sports for any heart problem?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had a severe viral infection within the last month? (for example Mononucleosis)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any current skin problems (itching, rashes, acne, warts, fungus or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out, become unconscious or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Have you had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
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Body Part	Normal	Abnormal	Comments
Neck			
Spine			
Shoulders			
Upper Arm			
Elbow			
Lower Arm			
Hand			
Wrist			
Pelvis			
Hip			
Thigh			
Knee			
Lower Leg			
Ankle			
Foot			

Comments: _____

Ht _____ Wt _____ BP _____ / _____ Pulse _____ Vision: R 20/ _____ L 20/ _____

System	Normal	Abnormal	Comments
Ears			
Nose			
Throat			
Chest			
Heart			
Lungs			
Abdomen			

Comments: _____

The following is the outcome of the physical:

- _____ Cleared for competition for the 2009-10 school year.
- _____ Cleared for competition for the 2009-10 school year. Please see recommendations below.
- _____ NOT cleared for competition for the 2009-10 school year. The following action should be taken.

 Physician Signature Date