

Connecticut Pre-participation Sports Evaluation

HISTORY to be filled out by Parent or Student (if over 18)

DATE OF EXAM _____

Name _____	Sex _____	Age _____	Date of birth _____
Grade _____	School _____	Sport(s) _____	
Address _____		Phone _____	
Personal physician _____			
<i>In case of emergency, contact</i>			
Name _____	Relationship _____	Phone (H) _____	(W) _____

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

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an ongoing or chronic illness (Diabetes, Epilepsy, Sickle Cell Disease, Kawasaki's Disease, Marfan's Syndrome or any handicap)?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	Do you bruise easily, take a long time to stop bleeding, or have frequent nose bleeds?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had infectious mononucleosis or hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler (for pain or shortness of breath)?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have hearing loss, tubes in your ears, or a perforated eardrum?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken any supplements, creatine, steroids, or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have kidney disease or dark brown bloody urine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have less than 2 kidneys or, in males, less than two testicles?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have diarrhea more than once a week, or black/bloody bowel movements (stools)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have lump(s) in the armpit or groin?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, check appropriate box and explain below:</i>		
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
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"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
Have you had a severe viral infection (for example, myocarditis or mononucleosis)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/calf
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper arm	<input type="checkbox"/> Foot	
7. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	Have you lost or gained more than 10 pounds in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Are you on a special diet?	<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"/>	14. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	15. Record the dates of your most recent immunizations (shots) for:		
Have you had a neck, spine or low back injury or pain?	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____ Measles _____		
8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____ Chickenpox _____		
9. Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>	Meningococcus _____		
Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY		
Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	16. When was your first menstrual period?		
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period?		
			How much time do you usually have from the start of one period to the start of another? _____		
			How many periods have you had in the last year? _____		
			What was the longest time between periods in the last year? _____		
			Do you ever require any medication to control menstrual pain? _____		
			If "yes" in the explanation below, include what medication and how much.		
			Explain "Yes" answers here: _____		

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/guardian _____ Date _____

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