Metropolitan State University of Denver ~ Department of Athletics
PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

Name of Patient: _____ Date of Birth: _____

Medicines & Allergies: Please list all of the prescription and over-the-counter & supplements (herbal & nutritional) that you are currently taking:

_____

_____

Do you currently or have you previously used: ☐ Tobacco ☐ Alcohol ☐ Marijuana ☐ Illegal drugs: _____

Do you have any allergies? ☐ Yes ☐ No If yes, write specific allergy & reaction: _____

_____

Mark an "X" in the appropriate box below.

Explain "Yes" answers below. If more space is needed, please use the back of this page.

GENERAL QUESTIONS	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reasons?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ (Pre)Diabetes ☐ Infections ☐ Other: _____		
3. Have you ever been hospitalized? If so, explain: _____ _____		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki Disease ☐ Other:_____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
13. Has a family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexpected car accident, or SIDS)?		
14. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
15. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**YES**	**NO**
16. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
17. Have you ever had any broken or fractured bones or dislocated joints?		
18. Do you have any incompletely healed injuries?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy , a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down Syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone or muscle or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	YES	NO
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you ever had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you ever had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with the doctor?		
52. Do you feel that there is any reason that you should not be able to compete?		
FEMALES ONLY	**YES**	**NO**
53. Have you ever had a menstrual period?		
54. How old were you when you had your first menstrual period?		
55. How many periods have you had in the last 12 months?		
56. Do you have painful or heavy menstrual periods?		
57. Do you take medication during your menstrual periods?		
58. Do you take birth control pills? If yes, which? _____		
59. Have you had a pelvic exam within the last year?		
MENTAL HEALTH QUESTIONS		
60. Have you ever been diagnosed with mental health issues including depression, anxiety, or bipolar?		
61. Have you ever been diagnosed with ADD or ADHD?		

Explain "Yes" answers here: _____

_____

_____

_____

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

Patient signature: _____ Date: _____