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: _____

Were you diagnosed with COVID-19? ☐ Yes ☐ No If yes, date of positive test: _____

Have you received your COVID19 Vaccination? Yes ☐ No ☐ If yes, which vaccine _____

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?	Select	
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ (Pre)Diabetes ☐ Infections ☐ Other:	Select	
3. Have you ever been hospitalized? If so, explain:	Select	
4. Have you ever had surgery?	Select	
HEART HEALTH QUESTIONS ABOUT YOU		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	Select	
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	Select	
7. Does your heart ever race or skip beats (irregular beats) during exercise?	Select	
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:	Select	
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)	Select	
10. Do you get lightheaded or feel more short of breath than expected during exercise?	Select	
11. Have you ever had an unexplained seizure?	Select	
12. Do you get more tired or short of breath more quickly than your friends during exercise?	Select	
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		
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)?	Select	
14. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	Select	
15. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	Select	
BONE AND JOINT QUESTIONS		
16. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?	Select	
17. Have you ever had any broken or fractured bones or dislocated joints?	Select	
18. Do you have any incompletely healed injuries?	Select	
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy , a brace, a cast, or crutches?	Select	
20. Have you ever had a stress fracture?	Select	
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)	Select	
22. Do you regularly use a brace, orthotics, or other assistive device?	Select	
23. Do you have a bone or muscle or joint injury that bothers you?	Select	
24. Do any of your joints become painful, swollen, feel warm, or look red?	Select	
25. Do you have any history of juvenile arthritis or connective tissue disease?	Select	

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

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: _____