PENNSTATE
Division of Student Affairs
University Health Services

The Pennsylvania State University
Preparticipation Physical Evaluation

HISTORY FORM

Name _____ **Sex** _____ **Age** _____ **Date of Birth** _____

Semester (circle one) 1 2 3 4 5 6 7 8 9 10 **Sport(s)** _____

Address _____

Student I.D. No. _____ **Phone** _____

Personal Physician _____

In case of emergency, contact:

Name _____ **Relationship** _____ **Phone(H)** _____ **(W)** _____

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

Date of Exam: _____

		Yes	No
1.	Has a doctor ever denied or restricted your participation in sport for any reason?	☐	☐
2.	Do you have an ongoing medical condition (like diabetes or asthma?)	☐	☐
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5.	Have you ever passed out or nearly passed out DURNING exercise?	☐	☐
6.	Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7.	Have you ever had discomfort, pain or pressure in your chest during exercise?	☐	☐
8.	Does your heart race or skip beats during exercise?	☐	☐
9.	Has a doctor ever told you that you have (check all that apply) ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection	☐	☐
10.	Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	☐	☐
11.	Has anyone in your family died for no apparent reason?	☐	☐
12.	Does anyone in your family have a heart problem?	☐	☐
13.	Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14.	Does anyone in your family have Marfan syndrome?	☐	☐
15.	Have you ever spent the night in a hospital?	☐	☐
16.	Have you ever had surgery?	☐	☐
17.	Have you ever had an injury, like a sprain, muscle or ligament tear or tendinitis that caused you to miss a practice or game? If yes, circle the affected area below:	☐	☐
18.	Have you had any broken or fractured bones, or dislocated joints? If yes, circle below:	☐	☐
19.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery , injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes circle below:	☐	☐

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes

20.	Have you ever had a stress fracture?	☐	☐
21.	Have you been told that you have or have had an x-ray for atlantoaxial (neck) instability?	☐	☐
22.	Do you regularly use a brace or assistive device?	☐	☐
23.	Has a doctor ever told you that you have asthma or allergies?	☐	☐
24.	Do you cough, wheeze or have difficulty breathing during or after exercise?	☐	☐
25.	Is there anyone in your family who has asthma?	☐	☐
26.	Have you ever used an inhaler or taken asthma medicine?	☐	☐
27.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28.	Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29.	Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30.	Have you had a herpes skin infection?	☐	☐
31.	Have you ever had a head injury or concussion?	☐	☐
32.	Have you been hit in the head and been confused or lost your memory?	☐	☐
33.	Have you ever had a seizure?	☐	☐
34.	Do you have headaches with exercise?	☐	☐
35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37.	When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39.	Have you had any problems with your eyes or vision?	☐	☐
40.	Do you wear glasses or contact lenses?	☐	☐
41.	Do you wear protective eyewear such as goggles or a face shield?	☐	☐
42.	Are you happy with your weight?	☐	☐
43.	Are you trying to gain or lose weight?	☐	☐
44.	Has anyone recommended that you change your weight or eating habit?	☐	☐
45.	Do you limit or carefully control what you eat?	☐	☐
46.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐

FEMALES ONLY

47.	Have you ever had a menstrual period?	☐	☐
48.	How old were you when you had your first menstrual period? _____		
49.	How many periods have you had in the last year? _____		
50.	Do you think you might be pregnant?	☐	☐

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 _____