New Jersey Department of Education
ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

Part A: HEALTH HISTORY QUESTIONNAIRE-Completed by the parent and student and reviewed by examining provider
Part B: PHYSICAL EVALUATION FORM-Completed by examining licensed provider with MD, DO, APN or PA

Part A: HEALTH HISTORY QUESTIONNAIRE

Today's Date:_____ **Date of Last Sports Physical:** _____

Student's Name: _____ Sex: M F (circle one) Age: ____ Grade: _____

Date of Birth: ____/___/_____ School: _____ District: _____

Sport(s): _____ Home Phone: (_____) _____

Provider Name (Medical Home): _____ Phone: _____ Fax: _____

EMERGENCY CONTACT INFORMATION

Name of parent/guardian: _____ Relationship to student: _____

Phone (work): _____ Phone (home):_____ Phone (cell): _____

Additional emergency contact: _____ Relationship to student: _____

Phone (work): _____ Phone (home):_____ Phone (cell): _____

Directions: Please answer the following questions about the student's medical history by **CIRCLING** the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

1. **Have you ever had, or do you currently have:**
   - a. Restriction from sports for a health related problem? Y / N / Don't Know
   - b. An injury or illness since your last exam? Y / N / Don't Know
   - c. A chronic or ongoing illness (such as diabetes or asthma)? Y / N / Don't Know
     - (1.) An inhaler or other prescription medicine to control asthma? Y / N / Don't Know
   - d. Any prescribed or over the counter medications that you take on a regular basis? Y / N / Don't Know
   - e. Surgery, hospitalization or any emergency room visit(s)? Y / N / Don't Know
   - f. Any **allergies** to medications? **Y / N / Don't Know**
   - g. Any allergies to bee stings, pollen, latex or foods? Y / N / Don't Know
     - (1.) If yes, check type of reaction:

       ☐ Rash ☐ Hives ☐ Breathing or other anaphylactic reaction
     - (2.) Take any medication/Epipen taken for allergy symptoms? (List below.) Y / N / Don't Know
   - h. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders? Y / N / Don't Know
   - i. A blood relative who died before age 50? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

_____
_____
_____
_____
_____

List all medications here:

Medication Name	Dosage	Frequency

2. **Have you ever had, or do you currently have, any of the following *head-related* conditions:**

a. Concussion or head injury (including "bell rung" or a "ding")?	Y / N / Don't Know
b. Memory loss?	Y / N / Don't Know
c. Knocked out?	Y / N / Don't Know
c. A seizure?	Y / N / Don't Know
d. Frequent or severe headaches (With or without exercise)?	Y / N / Don't Know
e. Fuzzy or blurry vision	Y / N / Don't Know
f. Sensitivity to light/noise	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

_____

_____

_____

3. **Have you ever had, or do you currently have, any of the following *heart-related* conditions:**

a. Restriction from sports for heart problems?	Y / N / Don't Know
b. Chest pain or discomfort?	Y / N / Don't Know
c. Heart murmur?	Y / N / Don't Know
d. High blood pressure?	Y / N / Don't Know
e. Elevated cholesterol level?	Y / N / Don't Know
f. Heart infection?	Y / N / Don't Know
g. Dizziness or passing out during or after exercise without known cause?	Y / N / Don't Know
h. Has a provider ever ordered a heart test (EKG, echocardiogram, stress test, Holter monitor)?	Y / N / Don't Know
i. Racing or skipped heartbeats?	Y / N / Don't Know
j. Unexplained difficulty breathing or fatigue during exercise?	Y / N / Don't Know
k. Any family member (blood relative):	
(1.) Under age 50 with a heart condition?	Y / N / Don't Know
(2.) With Marfan Syndrome?	Y / N / Don't Know
(3.) Died of a heart problem before age 50? If yes, at what age? _____	Y / N / Don't Know
(4.) Died with no known reason?	Y / N / Don't Know
(5.) Died while exercising? If yes, was it during or after? (Circle one.)	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

_____

_____

_____

4. **Have you ever had, or do you currently have, any of the following *eye, ear, nose, mouth or throat conditions:***

a. Vision problems?	Y / N / Don't Know
(1.) Wear contacts, eyeglasses or protective eye wear? (Circle which type.)	Y / N / Don't Know
b. Hearing loss or problems?	Y / N / Don't Know
(1.) Wear hearing aides or implants?	Y / N / Don't Know
c. Nasal fractures or frequent nose bleeds?	Y / N / Don't Know
d. Wear braces, retainer or protective mouth gear?	Y / N / Don't Know
e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)?	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

_____

_____

_____

5. **Have you ever had, or do you currently have, any of the following *neuromuscular/orthopedic conditions*:**

a. Numbness, a "burner", "stinger" or pinched nerve?	Y / N / Don't Know
b. A sprain?	Y / N / Don't Know
c. A strain?	Y / N / Don't Know
d. Swelling or pain in muscles, tendons, bones or joints?	Y / N / Don't Know
e. Dislocated joint(s)?	Y / N / Don't Know
f. Upper or lower back pain?	Y / N / Don't Know
g. Fracture(s), stress fracture(s), or broken bone(s)?	Y / N / Don't Know
h. Do you wear any protective braces or equipment?	Y / N / Don't Know

Explain all (yes) answers here (include relevant dates):

_____

_____

_____

6. **Have you ever had or do you currently have any of the following *general or exercise related conditions*:**

a. Difficulty breathing?	
(1.) During exercise?	Y / N / Don't Know
(2.) After running one mile?	Y / N / Don't Know
(3.) Coughing, wheezing or shortness of breath in weather changes?	Y / N / Don't Know
(4.) Exercise-induced asthma?	Y / N / Don't Know
i. Controlled with medication? (specify _____)	Y / N / Don't Know
ii. Experience dizziness, passing out or fainting?	Y / N / Don't Know
b. Viral infections (e.g. mono, hepatitis, coxsackie virus)?	Y / N / Don't Know
c. Become tired more quickly than others?	Y / N / Don't Know
d. Any of the following skin conditions:	
(1.) Cold sores/herpes, impetigo, MRSA, ringworm, warts?	Y / N / Don't Know
(2.) Sun sensitivity?	Y / N / Don't Know
e. Weight gain/loss (of 10 pounds or more)?	Y / N / Don't Know
(1.) Do you want to weigh more or less than you do now?	Y / N / Don't Know
f. Ever had feelings of depression?	Y / N / Don't Know
g. Heat-related problems (dehydration, dizziness, fatigue, headache)?	Y / N / Don't Know
(1.) Heat exhaustion (cool, clammy, damp skin)?	Y / N / Don't Know
(2.) Heat stroke (hot, red, dry skin)?	Y / N / Don't Know
(3.) Muscle cramps?	Y / N / Don't Know
h. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)?	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

_____
_____
_____

7. **Females only:**

Age of onset of menstruation:_____ How many menstrual periods in the last twelve (12) months? _____

How many periods missed in the last twelve (12) months? _____

8. **Males only:**

Have you had any swelling or pain in your testicles or groin? Y / N / Don't Know

PARENT/GUARDIAN SIGNATURE

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

_____ _____

Signature, Parent/Guardian or Student Age 18 Date of Signature:

THIS COMPLETED AND SIGNED HEALTH HISTORY MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAM.