PEDIATRIC ASSOCIATES OF THE NORTH SHORE

Patient: _____ DOB: _____

Filled out by: _____ Relationship: _____ Today's date: _____

Preparticipation Sports Form

This form is to be filled out by the patient and parent prior to seeing the physician.

1. Has a doctor ever denied or restricted your participation in sports for any reason?	Yes	No
2. Do you have any ongoing medical conditions? ¨ Asthma ¨ Anemia ¨ Diabetes ¨ Infections ¨ Other:	Yes	No
3. Have you ever spent the night in the hospital? Details:	Yes	No
4. Have you ever had surgery? Details:	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	Yes	No
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	Yes	No
7. Does your heart ever race or skip beats (irregular beats) during exercise?	Yes	No
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:	Yes	No
9. Do you get lightheaded or feel more short of breath than expected during exercise?	Yes	No
10. Have you ever had an unexplained seizure or a history of seizure disorder?	Yes	No
11. Do you get more tired or short of breath more quickly than your friends during exercise?	Yes	No
12. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?	Yes	No
13. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?	Yes	No
14. Do you cough, wheeze, or have difficulty breathing during or after exercise?	Yes	No
15. Have you ever used an inhaler or taken asthma medicine?	Yes	No
16. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	Yes	No
17. Have you had infectious mononucleosis (mono) or myocarditis within the last month?	Yes	No
18. Have you ever had a head injury or concussion?	Yes	No
19. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?	Yes	No
20. Do you have a history of seizure disorder?	Yes	No
21. Do you have headaches with exercise?	Yes	No
22. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	Yes	No
23. Have you ever been unable to move your arms or legs after being hit or falling?	Yes	No
24. Do you wear glasses or contact lenses?	Yes	No
25. Have you ever had an eating disorder?	Yes	No