

Connecticut Pre-participation Sports Evaluation

HISTORY to be filled out by Parent or Student (if over 18)

DATE OF EXAM _____

Name _____	Sex _____	Age _____	Date of birth _____
Grade _____	School _____	Sport(s) _____	
Address _____		Phone _____	
Personal physician _____			
<i>In case of emergency, contact</i>			
Name _____	Relationship _____	Phone (H) _____	(W) _____

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

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical? Do you have an ongoing or chronic illness (Diabetes, Epilepsy, Sickle Cell Disease, Kawasaki's Disease, Marfan's Syndrome or any handicap)?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight? Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler (for pain or shortness of breath)? Have you ever taken any supplements, creatine, steroids, or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)? Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out during or after exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain during or after exercise? Do you get tired more quickly than your friends do during exercise? Have you ever had racing of your heart or skipped heartbeats? Have you had high blood pressure or high cholesterol? Have you ever been told you have a heart murmur? Has any family member or relative died of heart problems or of sudden death before age 50? Have you had a severe viral infection (for example, myocarditis or mononucleosis)? Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious, or lost your memory? Have you ever had a seizure? Do you have frequent or severe headaches? Have you ever had numbness or tingling in your arms, hands, legs or feet? Have you ever had a stinger, burner or pinched nerve? Have you had a neck, spine or low back injury or pain?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
9. Do you cough, wheeze, or have trouble breathing during or after activity? Do you have asthma? Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
11. Have you had any problems with your eyes or vision? Do you wear glasses, contacts, or protective eyewear? Do you bruise easily, take a long time to stop bleeding, or have frequent nose bleeds? Have you had infectious mononucleosis or hepatitis? Do you have hearing loss, tubes in your ears, or a perforated eardrum? Do you have kidney disease or dark brown bloody urine? Do you have less than 2 kidneys or, in males, less than two testicles? Do you have diarrhea more than once a week, or black/bloody bowel movements (stools)? Do you have lump(s) in the armpit or groin?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever had a sprain, strain, or swelling after injury? Have you broken or fractured any bones or dislocated any joints? Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? <i>If yes, check appropriate box and explain below:</i> <input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip <input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin/calf <input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle <input type="checkbox"/> Upper arm <input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
13. Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your sport? Have you lost or gained more than 10 pounds in the past year? Are you on a special diet?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
14. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
15. Record the dates of your most recent immunizations (shots) for: Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____ Meningococcus _____					
FEMALES ONLY					
16. When was your first menstrual period? When was your most recent menstrual period? How much time do you usually have from the start of one period to the start of another? _____ How many periods have you had in the last year? _____ What was the longest time between periods in the last year? _____ Do you ever require any medication to control menstrual pain? _____ If "yes" in the explanation below, include what medication and how much.					
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 _____

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Connecticut Pre-participation Sports Evaluation

DATE OF PHYSICAL EXAMINATION

Name _____		Date of Birth _____	
Height _____	Weight _____	% Body Fat _____	Pulse _____
BP ____/____ (____/____, ____/____)			
Vision: R 20/ _____	L 20/ _____	Corrected: Y N	Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
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MEDICAL

Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

MUSCULOSKELETAL

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

* Station-based examination only

CLEARANCE

- Cleared
- Cleared after completing evaluation/rehabilitation for: _____
- _____
- _____
- Not cleared for: _____ Reason: _____
- _____
- _____

Recommendations: _____

Name of physician (print/type) _____ Date of physical _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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