



# Sports Medicine Center

Pomona Valley Hospital Medical Center • 1798 N. Garey Avenue • Pomona, CA 91767 • (909) 865-9810

Affiliated with PVHMC  
Physical Therapy &  
Rehabilitation

Date of Exam \_\_\_\_\_

## Preparticipation Physical Evaluation — HISTORY FORM

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Personal Physician \_\_\_\_\_

### In case of emergency, contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

### Explain "Yes" answers below. Circle questions you don't know the answers to.

		Yes	No			Yes	No	
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	24.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	25.	Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>	
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	26.	Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>	
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	27.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>	
5.	Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28.	Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	
6.	Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29.	Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>	
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30.	Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>	
8.	Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	31.	Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	
9.	Has a doctor ever told you that you have (check all that apply):			32.	Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/> High blood pressure			33.	Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/> A heart murmur			34.	Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/> High cholesterol			35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/> A heart infection			36.	Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>	
10.	Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	37.	When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>	
11.	Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>	
12.	Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	39.	Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	
13.	Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	40.	Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	
14.	Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	41.	Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>	
15.	Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	42.	Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>	
16.	Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	43.	Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>	
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 affected area below:	<input type="checkbox"/>	<input type="checkbox"/>	44.	Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>	
18.	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	45.	Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>	
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:	<input type="checkbox"/>	<input type="checkbox"/>	46.	Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>FEMALES ONLY</b>				
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	47.	Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>	
22.	Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	48.	How old were you when you had your first menstrual period?	_____		
23.	Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>	49.	How many periods have you had in the last 12 months?	_____		

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 \_\_\_\_\_