

## 2015-2016 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

### HEALTH HISTORY FORM TO BE COMPLETED BY PARENT/GUARDIAN Exam Date:

Name:
Sex:
Age:
Date of Birth:
Grade:
School:
Sport(s):
Address:
Phone:
Personal Physician:
Hospital Preference:

Explain "Yes" answers on following page.  
Circle questions you don't know the answers to.

	<b>Y</b>	<b>N</b>
12) Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
13) Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>
14) Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
15) Has a doctor told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
16) Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
17) Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
18) Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
19) Were you born without, are you missing, or do you have a nonfunctioning kidney, eye, testicle or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
20) Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
21) Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
22) Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
23) Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your "bell rung" or getting "dinged")?	<input type="checkbox"/>	<input type="checkbox"/>
24) Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
25) Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
26) Have you ever had numbness, tingling, or weakness in your arms or legs after being hit, falling, stingers or burners?	<input type="checkbox"/>	<input type="checkbox"/>
27) When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
28) 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"/>
29) Have you ever been tested for sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>
30) Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
31) Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
32) Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
33) Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
34) Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
35) Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
36) Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
37) Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>

**Females Only**

**Explain "Yes" Answers Here**

**2015-2016 PREPARTICIPATION PHYSICAL EVALUATION (COMPLETED BY PHYSICIAN)  
 ONLY COMPLETE IF NEEDING A PHYSICAL EXAM**

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient History Questions: Please tell me about your child...

- 1) Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?
- 2) Has your child ever had extreme shortness of breath during exercise?
- 3) Has your child had extreme fatigue associated with exercise (different from other children)?
- 4) Has your child ever had discomfort, pain or pressure in his/her chest during exercise?
- 5) Has a doctor ever ordered a test for your child's heart?
- 6) Has your child ever been diagnosed with an unexplained seizure disorder?
- 7) Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication?

Family History Questions: Please tell me about any of the following in your family...

- 8) Are there any family members who had sudden, unexpected, unexplained death before age 50? (including SIDS, car accidents, drowning, or near drowning)
- 9) Are there any family members who died suddenly of "heart problems" before age 50?
- 10) Are there any family members who have unexplained fainting or seizures?
- 11) Are there any relatives with certain conditions, such as:

Enlarged Heart

Hypertrophic Cardiomyopathy (HCM)

Dilated Cardiomyopathy (DCM)

Heart Rhythm problems:

Long QT Syndrome (LQTS)

Short QT Syndrome

Brugada Syndrome

Catecholaminergic Polymorphic Ventricular  
Tachycardia (CPVT)

Arrhythmogenic Right Ventricular  
Cardiomyopathy (ARVC)

Marfan Syndrome (Aortic Rupture)

Heart Attack, age 50 or younger

Pacemaker or Implanted Defibrillator

Deaf at Birth (Congenital Deafness)

Explain "Yes" Answers Here

I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.

\_\_\_\_\_  
 Signature of athlete

\_\_\_\_\_  
 Signature of parent/guardian

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of MD/DO/N

\_\_\_\_\_  
 D/N

\_\_\_\_\_  
 MD/N

\_\_\_\_\_  
 P/PA-C/CCSP Date:

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*(McDowell Rd. & Dysart Rd.)*

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1683 E. Florence Blvd., Ste. 7, AZ 85122  
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## CHANDLER

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*(W. Peoria Ave. & N. 43rd Ave.)*  
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*(Northern Ave. just E of 101)*

## MESA

1066 N. Power Rd., Ste. 101, AZ 85205  
*(N. Power Rd. & E. Brown Rd.)*  
4401 E. McKellips Rd., Ste. 102, AZ 85215  
*(E. McKellips Rd. & Greenfield Rd.)*  
3130 E. Baseline Rd., Ste. 105, AZ 85204

★ 8101 N. 19th Ave., Ste. A, AZ 85021  
*(N. 19th Ave. & E. Northern Ave.)*

## SCOTTSDALE

★ 7425 E. Shea Blvd., Ste. 108, AZ 85260  
*(E. Shea Blvd. & 74th St.)*

★ 20950 N. Tatum Blvd., Ste. 190, AZ 85050  
*(On Tatum Blvd. just north of the 101)*

## SUN CITY

★ 9745 W. Bell Rd., Ste. 105, AZ 85351  
*(N. 98th Ave. & W. Bell Rd.)*

## TEMPE

★ 914 N. Scottsdale Rd., Ste. 104, AZ 85281  
*(N. Scottsdale Rd. & E. Curry Rd.)*

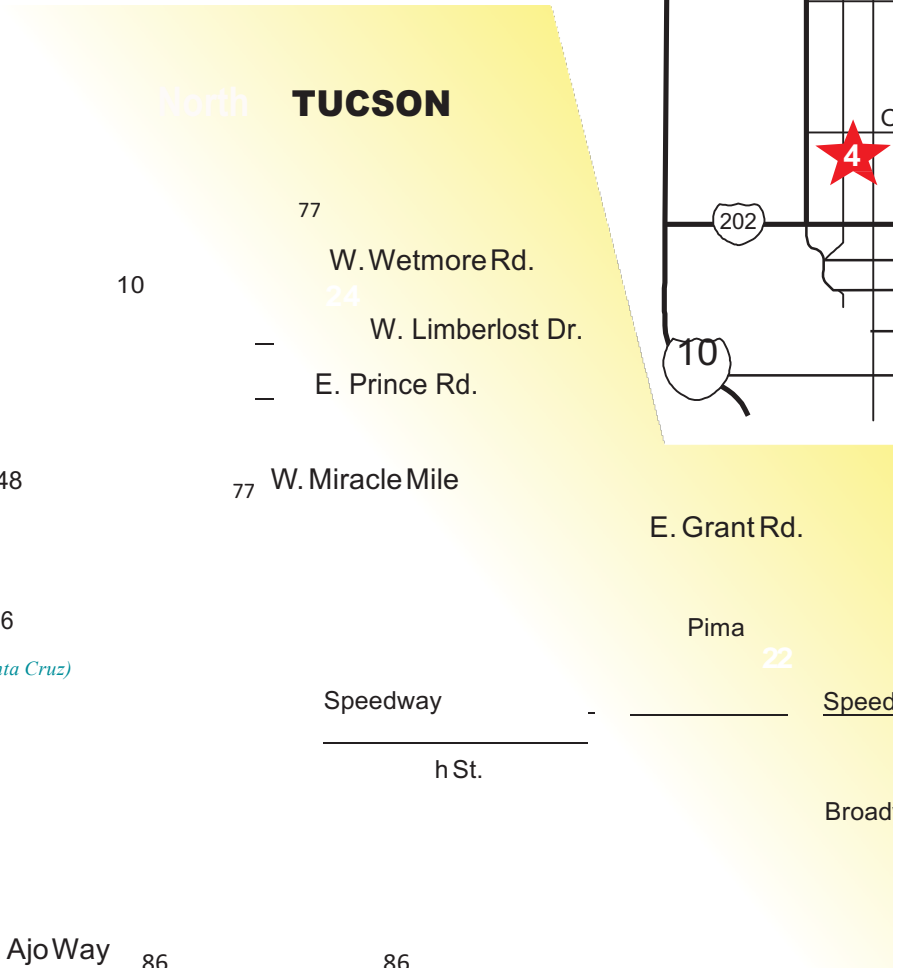
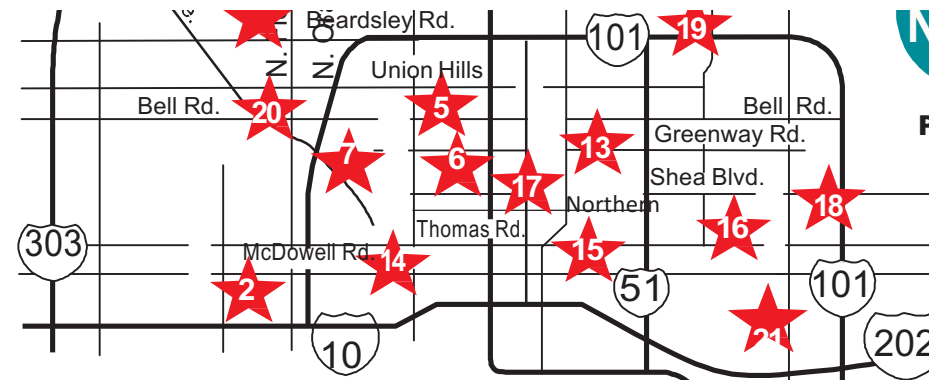
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