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_____
School_____ Grade____ Sport(s)_____
Address_____ Telephone _____
Personal physician_____
In case of emergency, contact:
Name_____ Relationship_____ Phone (H)_____ (W)_____

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

	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, Martan's Syndrome or any handicap)?	□	□
2. Have you ever been hospitalized overnight?	□	□
Have you ever had surgery?	□	□
3. Are you currently taking any prescription or non-prescription (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?	□	□
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?	□	□
5. Have you ever passed out 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?	□	□
6. Do you have any current skin problems (for example itching, rashes, acne, warts, fungus, or blisters)?	□	□
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?	□	□
8. Have you ever become ill from exercising in the heat?	□	□
9. Do you cough, wheeze, or have trouble breathing during during or after activity?	□	□
Do you have asthma?	□	□
Do you have seasonal allergies that require medical treatment?	□	□
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, teeth, hearing aid)?	□	□
11. Have you had any problems with your eyes or vision?	□	□
Do you wear glasses, contacts, or protective eye wear?	□	□
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?	□	□

	Yes	No
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?	□	□

If yes, check appropriate box and explain below:

□ Head □ Elbow □ Upper arm □ Knee
□ Neck □ Wrist □ Fore arm □ Shin / Calf
□ Back □ Hand □ Thigh □ Ankle
□ Chest □ Finger □ Hip □ Foot
□ Shoulder

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?	□	□
14. Do you feel stressed out?	□	□

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 t o 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_____

CONNECTICUT PRE-PARTICIPATION SPORTS EVALUATION

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*
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_____

Address_____ Telephone _____

Signature of physician _____ MD or DO