SAINT XAVIER UNIVERSITY HEALTH CENTER
PRE-PARTICPATION ATHLETIC PHYSICAL

HEALTH HISTORY FORM

Name_____ Date of birth_____/_____/_____ Date of exam_____/_____/_____

Gender_____ Age_____ Year in school_____ Sport(s)_____

Phone (_____)_____ Cell Home (please circle one)

MEDICATIONS: Please list all prescription and over-the-counter medicines/supplements that you are currently taking

_____

_____

DO YOU HAVE ANY ALLERGIES? □ Yes □ No

If yes, please identify the specific type: □ Medicine(s)_____

□ Environmental (i.e. pollen, dust, mold)_____ □ Food_____

□ Stinging insects_____ □ Other_____

Describe what happens when you have an allergic reaction_____

FAMILY HISTORY:

	Yes	No
Has any family member or relative died of heart problems or died suddenly at a young age without explanation (including drowning or unexplained car accident)?	___	___
Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	___	___
Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	___	___

*Please check the box if anyone **in your family** has any of the following conditions. If yes, please write what your relationship is to the person (mother/father/maternal grandmother, etc.):

□ Arrythmias (heart rhythm problems/abnormal pulse) _____

□ Marfan syndrome_____ □ Hypertrophic cardiomyopathy/heart failure_____

□ Heart murmurs_____ □ High blood pressure_____ □ Seizures_____

□ Heart attack_____ □ Stroke_____ □ Diabetes_____

□ Sickle cell anemia_____ □ Cancer_____ □ None of these

PERSONAL HEALTH HISTORY:

Have you ever been told that you have any of these health problems?

□ None of these

□ High blood pressure □ Heart murmur □ Heart infection

□ Kawasaki disease □ Juvenile arthritis □ Lupus

□ Marfan syndrome □ Asthma □ Anemia

□ Diabetes □ High cholesterol

□ Thyroid disease □ Connective tissue disease

□ Other_____

SOCIAL HISTORY:

	Yes	No
1. Do you smoke cigarettes?	___	___
If yes, how many packs and/or cigarettes per day? _____		
2. Do you vape?	___	___
3. Do you chew tobacco?	___	___
3. Do you drink alcohol?	___	___
If yes, how many drinks per week? _____		
4. Do you feel safe at home?	___	___

FEMALES ONLY: When was your last menstrual period? _____/_____/_____

How many periods have you had in the last 12 months?_____

Do you get very heavy and/or very painful periods? □ Yes □ No

Your Health	Yes	No
Has a doctor ever denied or restricted your participation in sports for any reason?		
Have you ever spent the night in the hospital?		
Have you ever had surgery?		
Have you ever passed out or nearly passed out DURING or AFTER exercise?		
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
Does your heart ever race or skip beats (irregular beats) during exercise?		
Has anyone ever ordered a test for your heart (i.e. ECG/EKG, echocardiogram)?		
Do you get lightheaded or feel more short of breath than expected during exercise?		
Have you ever had an unexplained seizure?		
Do you get more tired or short of breath more quickly than your friends during exercise?		
Have you had chest pain, palpitations, or shortness of breath after a COVID-19 infection?		
Do you cough, wheeze, or have difficulty breathing during or after exercise?		
Have you ever used an inhaler or taken asthma medicine?		
Were you born without or are you missing a testicle/ovary, kidney, spleen, eye or other organ?		
Do you have groin pain or a painful bulge or hernia in the groin area?		
Have you had infectious mononucleosis (mono) in the last month?		
Do you have any rashes, pressure sores, or other skin problems?		
Have you had a herpes or MRSA skin infection?		
Have you ever had a head injury or concussion?		
Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
Do you have a history of seizure disorder?		
Do you have headaches with exercise?		
Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
Have you ever become ill while exercising in the heat?		
Do you get frequent muscle cramps when exercising?		
Do you or someone in your family have sickle cell trait or disease?		
Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
Have you ever had any broken or fractured bones or dislocated joints?		
Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a case, or crutches?		
Have you ever had a stress fracture?		
Have you ever been told that you have or have you had an x-ray for neck instability?		
Do you regularly use a brace, orthodics, or other assistive device?		
Do you have a bone, muscle, or joint injury that bothers you?		
Do any of your joints become painful, swollen, feel warm, or look red?		
Have you had any problems with your eyes or vision?		
Have you had any eye injuries?		
Do you wear glasses or contact lenses?		
Do you wear protective eyewear, such as goggles or a face shield?		
Do you worry about your weight?		
Are you trying to or has anyone recommended that you gain or lose weight?		
Are you on a special diet or do you avoid certain types of foods?		
Are you using any supplements to try to gain muscle or lose weight?		
Have you ever had an eating disorder?		

Please explain any 'Yes' answers, or any medical conditions that were checked on the front of this sheet:

_____

_____

_____

_____

Signature of athlete_____ **Date**_____

Form adapted from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine recommendations for Preparticipation Physical Evaluation.