North Tonawanda City School District
Pre-Participation Physical Evaluation

Student Name:_____Sex:_____D.O.B._____

Grade_____Sports_____ Contact # on physical day _____

Student's Physician _____

Complete form in blue or black ink.

History: Please circle (Y)es or (N)o and comment on all YES answers on the backside of this form.

Y N 1. Has a doctor ever denied or restricted your participation in sports for any reason?
Y N 2. Do you have an ongoing medical condition?
Y N 3. Are you taking any prescription or non-prescription (over-the-counter) medicines or pills?
Y N 4. Do you have any allergies to medicines, pollens, foods, or stinging insects?
Y N 5. Have you ever passed out or nearly passed out DURING or AFTER exercise?
Y N 6. Have you ever had discomfort, pain, or pressure in your chest during exercise?
Y N 7. Does your heart race or skip beats during exercise?
Y N 8. Has your doctor ever told you that you have high blood pressure, high cholesterol, heart murmur, or a heart infection?
Y N 9. Has a doctor ever ordered a test for your heart (i.e. EKG, echocardiogram)?
Y N 10. Has anyone in your family ever died for no apparent reason?
Y N 11. Does anyone in your family have a heart problem?
Y N 12. Has any family member or relative died of heart problems or of sudden death before age 50?
Y N 13. Does anyone in your family have Marfan syndrome?
Y N 14. Have you ever spent the night in the hospital?
Y N 15. Have you ever had surgery?
Y N 16. Have you ever been told that you have or have had an x-ray for atlantoaxial (neck) instability?
Y N 17. Have you ever had an injury to a muscle, ligament, bone or joint that required an x-ray, MRI, CT, surgery, injection or physical therapy ? Please circle body parts in question.
Head Neck Shoulder Upper Arm Elbow Forearm Hand/Fingers Chest
Upper Back Lower back Hip Thigh Knee Calf/Shin Ankle Foot/Toes
Y N 18. Do you regularly wear a brace or assistive device?
Y N 19. Has a doctor ever told you that you have asthma or allergies?
Y N 20. Do you cough, wheeze, or have difficulty breathing during or after exercise?
Y N 21. Is there anyone in your family that has asthma?
Y N 22. Have you ever used an inhaler or taken asthma medication?
Y N 23. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?
Y N 24. Have you had infectious mononucleosis (mono) within the last month?
Y N 25. Do you have rashes, pressure sores, or other skin problems?
Y N 26. Have you had a herpes skin infection?
Y N 27. Have you ever had a head injury or been diagnosed with a concussion? **Describe how many, when and who diagnosed.**
Y N 28. Have you ever been hit in the head and been confused or lost your memory?
Y N 29. Have you ever had a seizure?
Y N 30. Do you have headaches with exercise?
Y N 31. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
Y N 32. Have you ever been unable to move your arms or legs after being hit or falling?
Y N 33. When exercising in the heat, do you have severe muscle cramps or become ill?
Y N 34. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?
Y N 35. Have you had any problems with your eyes or vision?
Y N 36. Are you trying to gain or lose weight?
Y N 37. Has anyone recommended you change your weight or eating habits?
Y N 38. Do you limit or carefully control what you eat?
Y N 39. Do you have any concerns that you would like to discuss with a doctor?

Females Only

Y N 40. Have you ever had a menstrual period? If yes, at what age was you're your first menstrual period? _____
How many periods have you had in the last 12 months? _____

Student Signature _____ **Date**_____

I hereby state that to the best of my knowledge, my answers to the above questions are complete and correct.

Parent Signature _____ **Date** _____ **Phone #** _____

By signing, I give permission for my child to receive her/his physical by a NTCSD healthcare provider.