Centennial Valley PEDIATRICS

HEALTH AND SPORTS SCREENING FORM

Please print, complete and bring this form to your appointment

	Y	N	Please check appropriate box
1.	O	O	Have you had a medical illness or injury since your last check up or sports physical?
	O	O	Do you have an ongoing or chronic illness?
2.	O	O	Have you ever been hospitalized overnight?
	O	O	Have you ever had surgery?
3.	O	O	Are you currently taking any prescription or non-prescription medication or using an inhaler?
	O	O	Have you ever taken supplements or vitamins to help you gain or lose weight or enhance your performance?
4.	O	O	Do you have any allergies (pollen,medicine, food,insects)? Have you ever had a rash or hives develop during or after exercise?
5.	O	O	Have you ever passed out during or after exercise?
	O	O	Have you ever been dizzy during or after exercise?
	O	O	Have you ever had chest pain during or after exercise?
	O	O	Do you get tired more quickly than your friends during exercise?
	O	O	Have you ever had racing of your heart or skipped heart beats?
	O	O	Have you had high blood pressure or cholesterol?
	O	O	Have you ever been told you have a heart murmur?
	O	O	Has any family member or relative died of heart problems before age 50?
	O	O	Have you had a severe viral infection (myocarditis or mononucleosis) within the last month?
	O	O	Has a physician ever denied or restricted your participation in sports for any heart problems?
6.	O	O	Do you have any current skin problems(for example itching, rashes, acne, warts, fungus or blisters)?
7.	O	O	Have you ever had a head injury or concussion? When?_____ How Many?_____ _____
	O	O	Have you ever been knocked out, become unconscious or lost your memory?
	O	O	Have you ever had a seizure?
	O	O	Have you had numbness or tingling in your arms, hands, legs or feet?
	O	O	Have you ever had a stinger, burner or pinched nerve?

Patient Name:_____

DOB:_____

Patient Signature:_____

Parent Signature:_____

	Y	N	
8.	O	O	Have you ever become ill from exercising in the heat?
9.	O	O	Do you cough, wheeze or have trouble breathing during or after activity?
	O	O	Do you have asthma?
	O	O	Do you have seasonal allergies requiring medical treatment?
10.	O	O	Do you use any special protective or corrective equipment or devises that aren't usually used for your sport or position (knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?
11.	O	O	Have you had any problems with your eyes/vision?
	O	O	Do you wear glasses, contacts or protective wear?
12.	O	O	Have you ever had a sprain, strain, fracture or dislocation of a muscle, tendon, bone or joint?

If yes, circle appropriate place and explain below:

HEAD NECK CHEST BACK SHOULDER ANKLE

UPPER ARM ELBOW FOREARM WRIST FINGER

HIP THIGH KNEE SHIN/CALF ANKLE FOOT

_____

_____

13.	O	O	Do you want to weigh more or less than you do now? MORE LESS
	O	O	Do you lose weight regularly to meet weight requirements for your sport?
14.	O	O	Are you currently seeing any Specialists or Therapists?

_____

_____

Females only:

15.	O	O	Have you begun menstruation?
	O	O	If yes, are you experiencing any problems (pain, irregularity, etc.)

*Explain:*_____

_____

_____

Date:_____

Date:_____