New Jersey Department of Education
ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

Part A: HEALTH HISTORY QUESTIONNAIRE

Completed by the parent and student and reviewed by examining provider

Student's Name: _____ Date of Last Sports Physical: _____

Directions: Please answer the following questions about the student's medical history by **CIRCLING** the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

1. Have you ever had, or do you currently have:

a. Restriction from sports for a health related problem? Y / N / Don't Know

b. An injury or illness since your last exam? Y / N / Don't Know

c. A chronic or ongoing illness (such as diabetes or asthma)? Y / N / Don't Know

1. An inhaler or other prescription medicine to control asthma? Y / N / Don't Know

d. Any prescribed or over the counter medications that you take on a regular basis? Y / N / Don't Know

e. Surgery, hospitalization or any emergency room visit(s)? Y / N / Don't Know

f. Any allergies to medications? Y / N / Don't Know

g. Any allergies to be stings, pollen, latex, or foods? Y / N / Don't Know

1. If yes, check type of reactions:

☐ Rash ☐ Hives ☐ Breathing or other anaphylactic reaction

2. Take any medication/Epipen taken for allergy symptoms? (list below) Y / N / Don't Know

h. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders? Y / N / Don't Know

i. A blood relative who died before age 50? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

_____

_____

_____

_____

_____

List all medications here:

Medication Name	Dosage	Frequency

2. Have you ever had, or do you currently have, any of the following head-related conditions:

a. Concussion or head injury (including "bell rung" or a "ding")?	Y / N / Don't Know
b. Memory loss	Y / N / Don't Know
c. Knocked out	Y / N / Don't Know
d. A seizure	Y / N / Don't Know
e. Fuzzy or blurry vision	Y / N / Don't Know
f. Sensitivity to light/noise	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

3. Have you ever had, or do you currently have, any of the following heart related conditions:

a. Restriction from sports for heart problems	Y / N / Don't Know
b. Chest pain or discomfort	Y / N / Don't Know
c. Heart murmur	Y / N / Don't Know
d. High blood pressure	Y / N / Don't Know
e. Elevated cholesterol level	Y / N / Don't Know
f. Heart infection	Y / N / Don't Know
g. Dizziness or passing out during or after exercise without known cause?	Y / N / Don't Know
h. Has a provider ever ordered a heart test (EKG, echocardiogram, stress test, Holter monitor)	Y / N / Don't Know
i. Racing or skipped heartbeats	Y / N / Don't Know
j. Unexplained difficulty breathing or fatigue during exercise	Y / N / Don't Know
k. Any family member (blood relative):	
1. Under age 50 with a heart condition	Y / N / Don't Know
2. With Marfan Syndrome	Y / N / Don't Know
3. Died of a heart problem before age 50? If yes, at what age? _____	Y / N / Don't Know
4. Died with no known reason	Y / N / Don't Know
5. Died while exercising? If yes, was it during or after? (Circle one)	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

4. Have you ever had, or do you currently have, any of the following eye, ear, nose, mouth or throat conditions:

a. Vision problems? Y / N / Don't Know

1. Wear contacts, eyeglasses or protective eye wear (circle which type Y / N / Don't Know

b. Hearing loss problems Y / N / Don't Know

1. Wear hearing aides or implants Y / N / Don't Know

c. Nasal fractures or frequent nose bleeds Y / N / Don't Know

d. Wear braces, retainer or protective mouth gear Y / N / Don't Know

e. Frequent strep or any other conditions of the throat (e.g. tonsillitis) Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

5. Have you ever had, or do you currently have, any of the following neuromuscular/orthopedic conditions:

a. Numbness, a "burner", "stinger" or pinched nerve Y / N / Don't Know

b. A sprain Y / N / Don't Know

c. A strain Y / N / Don't Know

d. Swelling or pain in muscles, tendons, bones or joints Y / N / Don't Know

e. Dislocated joint(s) Y / N / Don't Know

f. Upper or lower back pain Y / N / Don't Know

g. Fracture(s), stress fracture(s), or broken bone(s) Y / N / Don't Know

h. Do you wear any protective braces or equipment Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

6. Have you ever had, or do you currently have any of the following general or exercise related conditions:

a. Difficulty breathing	Y / N / Don't Know
1. During exercise	Y / N / Don't Know
2. After running one mile	Y / N / Don't Know
3. Coughing, wheezing or shortness of breath in weather changes	Y / N / Don't Know
4. Exercise-induced asthma	Y / N / Don't Know
i. Controlled with medication (specify _____)	Y / N / Don't Know
ii. Experience dizziness, passing out or fainting	Y / N / Don't Know
b. Viral infections (e.g. mono, hepatitis, coxsackie virus)	Y / N / Don't Know
c. Become tired more quickly than others	Y / N / Don't Know
d. Any of the following skin conditions	Y / N / Don't Know
1. Cold sores/herpes, impetigo, MRSA, ringworm, warts	Y / N / Don't Know
2. Sun sensitivity	Y / N / Don't Know
e. Weight gain/loss (of 10 pounds or more)	Y / N / Don't Know
1. Do you want to weigh more or less than you do now	Y / N / Don't Know
f. Ever had feelings of depression	Y / N / Don't Know
g. Heat-related problems (dehydration, dizziness, fatigue, headache)	Y / N / Don't Know
1. Heat exhaustion (cool, clammy, damp skin)	Y / N / Don't Know
2. Heat stroke (hot, red, dry skin)	Y / N / Don't Know
3. Muscle cramps	Y / N / Don't Know
h. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

_____

_____

_____

_____

_____

7. Females only:

Age of onset menstruation _____

How many menstrual periods in the last twelve (12) months _____

How many periods missed in the last twelve (12) months _____

8. Males only:

Have you had any swelling or pain in your testicles or groin? Y / N / Don't Know

PARENT / GUARDIAN SIGNATURE

I certify that the information provided herein in accurate to the best of my knowledge as of the date of my signature.

_____ _____

Signature of Parent/Guardian or Student Age 18 Date of Signature

This completed and signed Health History Questionnaire must be reviewed by the examining provider at the time of the medical exam.