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 ______
Grade ______ School __________________ Sport(s) __________________
Address __________________________ Phone (H) __________________ (W) ________________

Personal physician __________________________ Relationship ______ Phone __________________

In case of emergency, contact
Name ___________________________________ Relationship __________________ Phone (H) __________ (W) __________

Explain “yes” answers below.
Circle questions you don’t know the answer to.

1. Have you had a medical illness or injury since your last check up or sports physical?
   - Yes  No  ☐  ☐
   - Do you have an ongoing or chronic illness (Diabetes, Epilepsy, Sickle Cell Disease, Kawasaki’s Disease, Marfan’s Syndrome or any handicap)?
     - Yes  No  ☐  ☐

2. Have you ever been hospitalized overnight?
   - Yes  No  ☐  ☐
   - Have you ever had surgery?
     - Yes  No  ☐  ☐

3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler (for pain or shortness of breath)?
   - Yes  No  ☐  ☐
   - Have you ever taken any supplements, creatine, steroids, or vitamins to help you gain or lose weight or improve your performance?
     - Yes  No  ☐  ☐

4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?
   - Yes  No  ☐  ☐
   - Have you ever had a rash or hives develop during or after exercise?
     - Yes  No  ☐  ☐

5. Have you ever passed out during or after exercise?
   - Yes  No  ☐  ☐
   - Have you ever been dizzy during or after exercise?
     - Yes  No  ☐  ☐
   - Have you ever had chest pain during or after exercise?
     - Yes  No  ☐  ☐
   - Do you get tired more quickly than your friends do during exercise?
     - Yes  No  ☐  ☐
   - Have you ever had racing of your heart or skipped heartbeats?
     - Yes  No  ☐  ☐
   - Have you had high blood pressure or high cholesterol?
     - Yes  No  ☐  ☐
   - Have you ever been told you have a heart murmur?
     - Yes  No  ☐  ☐
   - Has any family member or relative died of heart problems or of sudden death before age 50?
     - Yes  No  ☐  ☐
   - Have you had a severe viral infection (for example, myocarditis or mononucleosis)?
     - Yes  No  ☐  ☐
   - Has a physician ever denied or restricted your participation in sports for any heart problems?
     - Yes  No  ☐  ☐

6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?
   - Yes  No  ☐  ☐
   - Have you ever had a head injury or concussion?
     - Yes  No  ☐  ☐
   - Have you ever been knocked out, become unconscious, or lost your memory?
     - Yes  No  ☐  ☐
   - Have you ever had a seizure?
     - Yes  No  ☐  ☐
   - Do you have frequent or severe headaches?
     - Yes  No  ☐  ☐
   - Have you ever had numbness or tingling in your arms, hands, legs or feet?
     - Yes  No  ☐  ☐
   - Have you ever had a stinger, burn or pinched nerve?
     - Yes  No  ☐  ☐
   - Have you had a neck, spine or low back injury or pain?
     - Yes  No  ☐  ☐
   - Have you ever become ill from exercising in the heat?
     - Yes  No  ☐  ☐

7. Do you cough, wheeze, or have trouble breathing during or after activity?
   - Yes  No  ☐  ☐
   - Do you have asthma?
     - Yes  No  ☐  ☐
   - Do you have seasonal allergies that require medical treatment?
     - Yes  No  ☐  ☐

8. 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, hearing aid)?
   - Yes  No  ☐  ☐

9. Have you ever had a medical illness or injury since your last check up or sports physical?
   - Yes  No  ☐  ☐
   - Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?
     - Yes  No  ☐  ☐
   - Have you ever had a rash or hives develop during or after exercise?
     - Yes  No  ☐  ☐

10. Have you ever had a medical illness or injury since your last check up or sports physical?
    - Yes  No  ☐  ☐
    - Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?
      - Yes  No  ☐  ☐
    - Have you ever had a rash or hives develop during or after exercise?
      - Yes  No  ☐  ☐

11. Do you have any problems with your eyes or vision?
    - Yes  No  ☐  ☐
    - Do you wear glasses, contacts, or protective eyewear?
      - Yes  No  ☐  ☐
    - Do you bruise easily, take a long time to stop bleeding, or have frequent nose bleeds?
      - Yes  No  ☐  ☐
    - Have you had infectious mononucleosis or hepatitis?
      - Yes  No  ☐  ☐
    - Do you have hearing loss, tubes in your ears, or a perforated eardrum?
      - Yes  No  ☐  ☐
    - Do you have kidney disease or dark brown bloody urine?
      - Yes  No  ☐  ☐
    - Do you have less than 2 kidneys or, in males, less than two testicles?
      - Yes  No  ☐  ☐
    - Do you have diarrhea more than once a week, or black/bloody bowel movements (stools)?
      - Yes  No  ☐  ☐
    - Do you have lump(s) in the armpit or groin?
      - Yes  No  ☐  ☐

12. Have you ever had a sprain, strain, or swelling after injury?
    - Yes  No  ☐  ☐
    - Have you broken or fractured any bones or dislocated any joints?
      - Yes  No  ☐  ☐
    - Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?
      - Yes  No  ☐  ☐

If yes, check appropriate box and explain below:

- Head ☐
- Elbow ☐
- Hip ☐
- Neck ☐
- Forearm ☐
- Thigh ☐
- Back ☐
- Wrist ☐
- Knee ☐
- Chest ☐
- Hand ☐
- Shin/calf ☐
- Shoulder ☐
- Finger ☐
- Ankle ☐
- Upper arm ☐
- Foot ☐

13. Do you want to weigh more or less than you do now?
    - Yes  No  ☐  ☐
    - Do you lose weight regularly to meet weight requirements for your sport?
      - Yes  No  ☐  ☐
    - Have you lost or gained more than 10 pounds in the past year?
      - Yes  No  ☐  ☐
    - Are you on a special diet?
      - Yes  No  ☐  ☐

14. Do you feel stressed out?
    - Yes  No  ☐  ☐

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?
    - Yes  No  ☐  ☐
    - How many periods have you had in the last year?
      - Yes  No  ☐  ☐
    - How much time do you usually have from the start of one period to the start of another?
      - Yes  No  ☐  ☐
    - How many periods have you had in the last year?
      - Yes  No  ☐  ☐
    - What was the longest time between periods in the last year?
      - Yes  No  ☐  ☐
    - Do you ever require any medication to control menstrual pain?
      - Yes  No  ☐  ☐

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
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<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>% Body Fat</th>
<th>Pulse</th>
<th>BP (<em><strong>/</strong></em>)</th>
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<tr>
<th>Vision: R 20/___</th>
<th>L 20/___</th>
<th>Corrected:</th>
<th>Pupils:</th>
<th>Equal</th>
<th>Unequal</th>
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<td></td>
<td></td>
<td>Y</td>
<td>N</td>
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## 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 ____________________________ Phone __________

### Signature of physician ____________________________ MD or DO