HOPS

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the provider. The provider should keep this form in the chart.)

NAME:_____ **Date of Birth**_____

Sex_____ **Age**_____ **Grade**_____ **School**_____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal/nutritional) that you are currently taking.

Do you have any allergies? Yes_____ No_____ If yes, please identify specific allergy below.
_____Medicines _____ Pollen _____Food _____Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	YES	NO		27. Do you have groin pain or a painful bulge or hernia in the groin area?		
1 .Has a doctor ever denied or restricted your participation in sports for any reason?				29. Do you have any rashes, pressure sores, or other skin problems?		
2. Do you have any ongoing medicals conditions? If so, please identify ☐ Asthma ☐ Anemia ☐ Diabetes Infections				30. Have you had a herpes or MRSA skin infection?		
3. Have you ever spent the night in the hospital?				31. Have you ever had a head injury or concussion?		
4. Have you ever had surgery?				27. Do you have groin pain or a painful bulge or hernia in the groin area?		
HEART HEALTH QUESTIONS ABOUT YOU	YES	NO		29. Do you have any rashes, pressure sores, or other skin problems?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?				30. Have you had a herpes or MRSA skin infection?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?				31. Have you ever had a head injury or concussion?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?				32. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High Cholesterol ☐ A heart infection ☐ Kawasaki disease ☐ Other_____				33. Do you have a history of seizure disorder?		
				34. Do you have headaches with exercise?		
				35. Have you ever had numbness, tingling, or weakness in your arms, or legs after being hit or falling?		
				36. Have you ever been unable to move your arms or legs after being hit or falling?		
				37. Have you ever become ill while exercising in the heat?		
9. Has a doctor ever ordered a test for your heart ? (For example, ECG/EKG, echocardiogram)				38. Do you get frequent muscle cramps when exercising?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?				38. Have you had any problems with your eyes or vision?		
11. Have you ever had an unexplained seizure?				39.Have you had any eye injuries?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?				40. Do you wear glasses or contact lenses?		
HEART HEALTH QUESTIONS ABOUT OUR FAMILY	YES	NO		41. Do you wear protective eyewear, such as goggles or a face shield?		
13. Has any family memer or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?				42. Are you trying or has anyone recommended that you gain or lose weight?		
14. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?				42. Are you on a special diet or do you avoid certain types of foods?		
15. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?				43. Are you on a special diet or do you avoid certain types of foods?		
BONE AND JOINT QUESTIONS	YES	NO		44. Have you ever had an eating disorder?		
16. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?				45. Do you have any concerns that you would like to discuss with a doctor?		
17. Have you ever had any broken or fractured or dislocated joints?				**FEMALES ONLY**	YES	NO
18. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?				46. Have you ever had a menstrual period?		
19. Have you ever had a stress fracture?				47. How old were you when you had your first menstrual period?		
20. Do you regularly use a brace, orthotics, or other assistive device?				48. How many periods have you had in the last 12 months?		
21. Do you have a bone, muscle, or joint injury that bothers you?						
22. Do any of your joints become painful, swollen, feel warm, or look red?				**Explain "yes" answers here:**		
MEDICAL QUESTIONS	YES	NO				
23. Do you cough, wheeze, or have difficulty breathing during or after exercies?						
24. Have you ever used an inhaler or taken asthma medicine?						
25. Is there anyone in your family who has asthma?						
26. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?						

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

X Signature of Athlete_____ Date:_____

X Signature of Parent/Guardian_____ Date:_____