

New Jersey Department of Education
ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM
Part A: HEALTH HISTORY QUESTIONNAIRE
(To be completed by the parent and student)
(Pursuant to N.J.A.C. 6A:16 *Programs to Support Student Development*)

Today's Date: _____ **Date of Last Physical:** _____

Student's Name: _____ Sex: M F (circle one) Age: _____

Date of Birth: _____ Sport: _____ Home Phone: _____

Grade: _____ School: _____ District: _____

Physician: _____ Phone: _____ Fax: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to student: _____

Phone (work): _____ Phone (home): _____

Phone (cell): _____

Directions: Please answer the following questions about the student's medical history. Explain all "yes" responses at the bottom of the page. Please respond to all questions.

1. Have you had or do you currently have:

- | | |
|-------------------------------------------------------------------------------------|--------------------|
| a. A sports physical within the past 365 days? | 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. Use 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 bee stings, pollen, latex or foods? | Y / N / Don't Know |
| 1. Type of reaction: Rash? Hives? Other skin condition? (Circle all that apply.) | Y / N / Don't Know |
| 2. Take any medication/Epipen taken for allergy symptoms? (List below.) | Y / N / Don't Know |
| h. Any anemias or blood disorders? | Y / N / Don't Know |

2. Have you had or do you currently have any of the following *head-related* conditions since your last physical:

- | | |
|---------------------------------------------------|--------------------|
| a. Concussion requiring a physician's evaluation? | Y / N / Don't Know |
| 1. How often and when? (Answer below.) | |
| b. Memory loss or been knocked out? | Y / N / Don't Know |
| c. A seizure? | Y / N / Don't Know |
| d. Frequent or severe headaches? | Y / N / Don't Know |

3. Have you had or do you currently have any of the following *heart-related* conditions since your last physical:

- | | |
|---------------------------------------------------------|--------------------|
| a. Chest pain? | Y / N / Don't Know |
| b. Heart murmur? | Y / N / Don't Know |
| c. High blood pressure or elevated cholesterol level? | Y / N / Don't Know |
| d. Restriction from sports for heart problems? | Y / N / Don't Know |
| e. Any family member or relative: | |
| 1. Die of a heart problem before age 35? | Y / N / Don't Know |
| 2. Die of a heart problem before age 50? | Y / N / Don't Know |
| 3. Die with no known reason? | Y / N / Don't Know |
| 4. Die while exercising? During or after? (Circle one.) | Y / N / Don't Know |
| 5. With Marfan's Syndrome? | Y / N / Don't Know |

