INSTITUTE OF SPORTS AND SPORTS MEDICINE OF SERBIA

PREPARTICIPATION PHYSICAL EVALUATION

Date of Exam _____

Name		Sex		Age	
Date of birth		Sport(s)			
Address					
Phone					

(Explain "Yes" answers below. Circle questions if you do not know the answers.)

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have an ongoing medical condition (like diabetes or asthma)?		
3. Are you currently taking any prescription or nonprescription (over the counter) medicines or pills?		
4. Do you have allergies to medicines, pollens, foods, or stinging insects?		
5. Have you ever passed out or nearly passed out DURING exercise?		
6. Have you ever passed out or nearly passed out AFTER exercise?		
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?		
8. Does your heart race or skip beats during exercise?		
9. Has a doctor ever told you that you have (check all that apply):		
☐ High blood pressure ☐ A heart murmur		
☐ High cholesterol ☐ A heart infection		
10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)		
11. Has anyone in your family died for no apparent reason?		
12. Does anyone in your family have a heart problem?		
13. Has any family member died of heart problems or sudden death before age 50?		
14. Does anyone in your family have Marfan syndrome?		
15. Have you ever spent the night in a hospital?		
16. Have you ever had surgery?		
17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below:		
Head / Neck / Shoulder / Upper Arm / Elbow / Forearm / Hand/Fingers / Chest		
Upper Back / Lower Back / Hip / Thigh / Knee / Calf/Shin / Ankle / Foot/Toes		
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:		
Head / Neck / Shoulder / Upper Arm / Elbow / Forearm / Hand/Fingers / Chest		
Upper Back / Lower Back / Hip / Thigh / Knee / Calf/Shin / Ankle / Foot/Toes		
19. Have you had a bone or joint injury that required xrays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:		
Head / Neck / Shoulder / Upper Arm / Elbow / Forearm / Hand/Fingers / Chest		
Upper Back / Lower Back / Hip / Thigh / Knee / Calf/Shin / Ankle / Foot/Toes		
20. Have you ever had a stress fracture?		

21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?		
22. Do you regularly use a brace or assistive device?		
23. Has a doctor ever told you that you have asthma or allergies?		
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
25. Is there anyone in your family who has asthma?		
26. Have you ever used an inhaler or taken asthma medicine?		
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?		
28. Have you had infectious mononucleosis (mono) within the last month?		
29. Do you have any rashes, pressure sores, or other skin problems?		
30. Have you had a herpes skin infection?		
31. Have you ever had a head injury or concussion?		
32. Have you been hit in the head and been confused or lost your memory?		
33. Have you ever had a seizure?		
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. When exercising in the heat, do you have severe muscle cramps or become ill?		
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
39. Have you had any problems with your eyes or vision?		
40. Do you wear glasses or contact lenses?		
41. Do you wear protective eyewear, such as goggles or a face shield?		
42. Are you happy with your weight?		
43. Are you trying to gain or lose weight?		
44. Has anyone recommended that you change your weight or eating habits?		
45. Do you limit or carefully control what you eat?		
46. Do you have any concerns that you would like to discuss with a doctor?		

FEMALES ONLY

47. Have you ever had a menstrual period?
48. How old were you when you had your first menstrual period? _____
49. How many periods have you had in the last 12 months? _____

Explain “Yes” answers here:

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_____

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

Signature of Athlete_____ Date _____