

## FORM B -- NIAA PRE-PARTICIPATION HISTORY FORM

<b>HISTORY</b>	DATE OF EXAM: _____
NAME: _____	SEX: _____ AGE: _____ D.O.B.: _____
GRADE: _____	SCHOOL: _____ SPORT(S): _____
ADDRESS: _____	PHONE: _____
PERSONAL PHYSICIAN: _____	
IN CASE OF EMERGENCY, CONTACT - NAME: _____	
RELATIONSHIP: _____	PHONE (H): _____ (W): _____

<p><b>EXPLAIN "YES" ANSWERS BELOW.</b></p> <p><b>CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWERS TO.</b></p>
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	<i>YES</i>	<i>NO</i>
1. Do you have a chronic medical condition (asthma, diabetes, high blood pressure, etc.)?	_____	_____
2. Have you ever been hospitalized overnight?	_____	_____
3. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?	_____	_____
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insect)?	_____	_____
5. a. Have you passed out or been dizzy during exercise?	_____	_____
b. Have you had chest pain (or pressure) with exercise?	_____	_____
c. Have you had excessive unexplained shortness of breath or fatigue with exercise?	_____	_____
d. Is there a family history of premature death or morbidity from cardiovascular disease in a relative younger than age 50?	_____	_____
e. Is there any history in your family of hypertrophic cardiomyopathy, dilated cardiomyopathy long QT syndrome or Marfan's syndrome?	_____	_____
f. Has a physician denied or restricted your participation in sports for any heart problem?	_____	_____
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	_____	_____
7. a. Have you had a head injury or concussion?	_____	_____
b. Have you been knocked out, become unconscious, or lost your memory?	_____	_____
c. Have you had a seizure?	_____	_____
d. Do you have frequent or severe headaches?	_____	_____
e. Have you had numbness or tingling in your arms, hands, legs, or feet?	_____	_____
8. Have you become ill from exercising in the heat?	_____	_____
9. Do you cough, wheeze, or have trouble breathing during or after activity?	_____	_____

**Over >**

- |                                                                                                                                                                                                                                    | <b>YES</b> | <b>NO</b> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-----------|
| 10. a. 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)? | _____      | _____     |
| b. Are you missing an eye, kidney, testicle or ovary?                                                                                                                                                                              | _____      | _____     |
| 11. a. Have you had any problems with your eyes or vision?                                                                                                                                                                         | _____      | _____     |
| b. Do you wear glasses, contacts, or protective eyewear?                                                                                                                                                                           | _____      | _____     |
| 12. a. Have you had any problems with pain or swelling in muscles, tendons, bones, or joints?                                                                                                                                      | _____      | _____     |

b. If yes, check appropriate item and explain below.

- |                 |                 |                 |
|-----------------|-----------------|-----------------|
| _____ Head      | _____ Elbow     | _____ Hip       |
| _____ Neck      | _____ Forearm   | _____ Thigh     |
| _____ Back      | _____ Wrist     | _____ Knee      |
| _____ Chest     | _____ Hand      | _____ Shin/Calf |
| _____ Shoulder  | _____ Finger(s) | _____ Ankle     |
| _____ Upper Arm | _____ Foot      | _____ Toe(s)    |

- |                                                                                        |       |       |
|----------------------------------------------------------------------------------------|-------|-------|
| 13. Are you actively trying to gain or lose weight?                                    | _____ | _____ |
| 14. Would you like to talk to someone about stress, anger, depression or other issues? | _____ | _____ |

15. Record the dates of your most recent immunizations (shots) for:

Tetanus _____	Measles _____
Hepatitis B _____	Chickenpox _____

**FEMALES ONLY**

16. When was your first menstrual period? \_\_\_\_\_
- When was your most recent menstrual period? \_\_\_\_\_
- How much time do you usually have from the start of one period to the start of another? \_\_\_\_\_
- How many periods have you had in the last year? \_\_\_\_\_
- What was the longest time between periods in the last year? \_\_\_\_\_

**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
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