Parker Family Care

Sports Physical Questionnaire

Name_____ Date of Birth_____

Do you have an ongoing medical condition (like diabetes or asthma)?
O Yes O No

Are you currently taking any prescription or nonprescription (over the counter) medicines?
O Yes O No

Do you have any allergies to medicines, pollens, foods, or stinging insects?
O Yes O No

Have you ever passed out or nearly passed out DURING or AFTER exercise?
O Yes O No

Have you ever had discomfort, pain, or pressure in your chest during exercise?
O Yes O No

Does your heart race or skip beats during exercise?
O Yes O No

Do you cough, wheeze, or have difficulty breathing during or after exercise?
O Yes O No

Were you born without or are you missing a kidney, eye, testicle, or any other organ?
O Yes O No

Have you ever had a head injury or concussion?
O Yes O No

Have you had any recent injuries (sprains or fractures)?
O Yes O No

Have you ever had a seizure?
O Yes O No

Have you ever had problems with your eyes or vision?
O Yes O No

Are you happy with your weight?
O Yes O No

Do you have any concerns or questions about sex or birth control?
O Yes O No

Do you have any concerns you would like to discuss with the doctor?
O Yes O No

Has anyone in your family died for no apparent reason under the age 40?
O Yes O No

Does anyone in your family have heart problems?
O Yes O No

Do you feel stressed out or under a lot of pressure?
O Yes O No

Do you feel safe at home or school?
O Yes O No

During the past 6 months have you tried cigarette smoking, chewing tobacco, or snuff?
O Yes O No

During the past 6 months have you had at least one drink of alcohol?
O Yes O No

Are you currently taking or plan to take any supplements to improve your athletic performance?
O Yes O No

Reviewed by _____ Date _____