Alliance Pediatrics, PA
Pre-Participation Medical History Questionairre

Patient's Name: ______________________________ **Patient DOB:** ___/____/_____
Pediatrician: ______________________________ **Date:** ___________

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

#	Question	Y	N
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 or after exercise?		
6	Have you ever had discomfort, pain, or pressure in your chest during exercise?		
7	Does your heart race or skip beats?		
8	Has a doctor ever told you that you have (check all that apply): __ High blood pressure __High cholesterol __Heart murmur __ Heart infection		
9	Has anyone in your family died for no apparent reason?		
10	Does anyone in your family have a heart problem?		
11	Has any family member or relative died of heart problems or sudden death before age 50?		
12	Have you ever had surgery?		
13	Do you cough, wheeze, or have difficulty breathing during or after exercise?		
14	Have you ever had a head injury or concussion?		
15	Do you have headaches with exercise?		
16	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
17	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
18	Have you had any problems with your eyes or vision?		
19	Do you wear glasses or contact lenses?		
20	Are you happy with your weight?		
21	Do you have any concerns that you would like to discuss with a doctor? ________________________________		
22	Do you feel safe?		
23	Have you tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?		
24	Does anyone in your house smoke?		

25 Please explain "Yes" answers below: ________________________________

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Year completed: ________ ***Provider:*** *Initial box once reviewed*