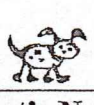


Alliance Pediatrics, PA

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.

FOR PARENT TO FILL OUT

		Y	N
1	Has a doctor ever denied/restricted your teen's participation in sports for any reason?		
2	Does your teen have an ongoing medical condition (check all that apply): __ Asthma __Diabetes __Seizure Disorder __ Other: _____		
3	Is your teen currently taking any prescription or OTC medicines or energy supplements?		
4	Does your teen have allergies to medicines, pollens, foods or stinging insects?		
5	Has your teen been diagnosed with: (check all that apply): __ High blood pressure __High cholesterol __Heart murmur __ Heart infection		
6	Has anyone in your family died for no apparent reason?		
7	Does anyone in your family have a heart problem?		
8	Has any family member died of heart problems or sudden death < age 50?		
9	Has your teen ever had surgery?		
10	Has your teen ever had a head injury or concussion?		
11	Does your teen or family member have sickle cell trait or sickle cell disease?		
12	Is your teen seeing a specialist that we have not referred you to?		
	Please explain "Yes" answers:		

FOR PATIENT TO FILL OUT

		Y	N
1	Have you ever passed out or nearly passed out during exercise?		
2	Have you ever had discomfort, pain or pressure in your chest during exercise?		
3	Does your heart race or skip beats?		
4	Do you cough, wheeze or have difficulty breathing during or after exercise?		
5	Do you have headaches with exercise?		
6	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
7	Have you had any problems with your eyes or vision?		
8	Do you wear glasses or contacts?		
9	Have you tried cigarette smoking, even 1 or 2 puffs? Y / N Do you currently smoke?		
10	Are you happy with your weight?		
11	Do you feel safe?		
12	Do you have any concerns that you would like to discuss with the doctor?		
	Please explain "Yes" answers :		

Over the past 2 weeks, how often have you been bothered by any of the following problems?
(Circle your answer)

		Not at all	Several Days	More than 1/2 of days	Nearly every day
13	Little interest or pleasure in doing things	0	1	2	3
14	Feeling down, depressed or hopeless	0	1	2	3

Year Completed: _____ PHQ2 _____ Provider Initial reviewed: _____