

Does your child brush their teeth at least two times daily?

Yes No Unsure

SLEEP

Does your child snore on a regular basis?

Yes No Unsure

How many hours per night does your child usually sleep?

hours

Do you have any concerns about your child's sleep?

Yes No Unsure

If yes, please describe: _____

SAFETY

Do you monitor your child's TV and computer use?

Yes No Unsure

Does your child wear a helmet when biking/skiing/skating?

Yes No Unsure

Does your child wear a seatbelt or sit in a booster in the car?

Yes No Unsure

Does your child usually use sunscreen/ hats/ other sun protection?

Yes No Unsure

Does your child know how to stay safe around water (pools, rivers, etc.)?

Yes No Unsure

Have you discussed stranger awareness with your child?

Yes No Unsure

Does your child know how to use 911 in an emergency?

Yes No Unsure

If guns are in the home, are they safely secured?

Yes No Unsure

MENTAL HEALTH

Do you have concerns about your child's mood (anxiety, depression)?

Yes No Unsure

Do you have concerns about your child's relationship with parents or siblings?

Yes No Unsure

Do you have concerns about how to discipline/ set appropriate limits?

Yes No Unsure

If yes, please explain: _____

FOR GIRLS ONLY

Has your daughter had her first period?

Yes No Unsure

If yes, do you have any questions about her periods?

Yes No Unsure

RISK ASSESSMENT FOR ABNORMAL LIPID PROFILE (SUCH AS HIGH CHOLESTROL)

Did any of your child's parents or grandparents have significant heart disease at or before 55 years of age (had heart attack, stroke, angioplasty, angina, or bypass surgery)?

Yes No Unsure

Do either of the child's parents have high cholesterol level of 240 or higher?

Yes No Unsure

Do you have any other concerns you would like to discuss today?

Yes No

If yes, what are your concerns: _____

Nataloni Pediatrics, P.C.
Pre-Participation Physical Evaluation

Patient's Name: _____ Date of Birth: _____ Age: _____

The following questions should be completed by student or parent. Please explain "yes" answers where indicated. Circle questions you don't know answers to.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last check-up or sports physical?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing illness?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been hospitalized overnight?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had surgery?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills, or using an inhaler?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your Performance?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any allergies (for example: to pollen, medicine, food or stinging insects)?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had a rash or hives develop during or after exercise?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever passed out during or after exercise?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever been dizzy during or after exercise?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had chest pain during or after exercise?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you get tires more quickly than your friends do during exercise?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever had racing of your heart or skipped heartbeats?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had high blood pressure or high cholesterol?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever been told you have a heart murmur?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Has any family member or relative died of heart problems or sudden death before age 50?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you had a severe viral infection (for example: myocarditis or mononucleosis) within the last month?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Has a physician ever denied or restricted your participation in sports for any heart problems?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus or blisters)?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you ever had a head injury or concussion?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you ever been knocked out, become unconscious or lost your memory?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you ever had a seizure?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|---|--------------------------|--------------------------|
| 23. Do you have frequent or severe headaches?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have you ever had numbness or tingling in your arms, hands, legs or feet?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Have you ever had a stinger, burner or pinched nerve?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever become ill from exercising in the heat?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you cough, wheeze or have trouble breathing during or after activity?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you have asthma?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you have seasonal allergies that require medical treatment?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. 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 for your teeth, hearing aid)?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you had any problems with your eyes or vision?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Do you wear glasses, contacts or protective eyewear?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you ever had a sprain, strain or swelling after injury?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Have you broken or fractured any bones or dislocated any joints?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?
If yes, check appropriate blank and explain in the space provided:
___Head ___Elbow ___Hip ___Neck ___Forearm ___Thigh ___Back ___Wrist ___Knee
___Chest ___Hand ___Shin/Calf ___Shoulder ___Finger ___Ankle ___Upper Arm ___Foot
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Do you want to weigh more or less than you do now?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. Do you lose weight regularly to meet weight requirements for your sport?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Do you feel stressed out?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Record the dates of your most recent immunizations (shots) for:
Tetanus: _____
Measles: _____
Hepatitis B: _____
Chickenpox: _____ | | |
| FEMALES ONLY – Optional – | | |
| 40. When was your first menstrual period?
_____ | | |
| 41. When was your most recent menstrual period?
_____ | | |
| 42. How much time do you usually have from the start of one period to the start of another?
_____ | | |
| 43. How many periods have you had in the last year?
_____ | | |
| 44. What was the longest time between periods in the last year?
_____ | | |

Signature of parent/guardian: _____ Date: _____