Paint Creek Pediatrics
200 Diversion Street, Ste 20
Rochester, MI 48307
(248) 656-3440

Athlete School Sports Participation Parent

To be completed by parent:

Name _____ Sex _____ Age _____ Date of Birth _____

Grade _____ School _____ Sport (s) _____

Please review all questions and answer then to the best of your ability.

	YES	NO	DON'T KNOW
Has anyone in your family dies suddenly before the age of 50 or have other heart problems?	☐	☐	☐
Is there a history of young people in your family who have had congenital or other heart disease: cardiomypathy, abnormal heart rhythms, long QT, OR Marfan's syndrome? (You may write "I don't understand there terms" and initial this item, it appropriate).	☐	☐	☐
Does your heart race or skip beats during exercise?	☐	☐	☐
Has a doctor ever told you that you have:	☐	☐	☐
High blood pressure	☐	☐	☐
High cholesterol	☐	☐	☐
A heart murmur	☐	☐	☐
A heart infection			
Has a doctor ever ordered a test for your heart? (For example EKS, echocardiogram)	☐	☐	☐
Have you ever broken a bone, had to wear a cast, or had an injury to any joint?	☐	☐	☐
Do you have a history of concussion (getting knocked out) or seizures?	☐	☐	☐
Have you ever suffered from a heart related illness (heart stroke)?	☐	☐	☐

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	YES	NO	DON'T KNOW
Have you ever passed out or nearly passed out during exercise?	☐	☐	☐
Has the doctor ever told you that you have asthma?	☐	☐	☐
Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐	☐
Is there anyone in your family who had asthma?	☐	☐	☐
Have you ever used an inhaler or taken asthma medication?	☐	☐	☐
Do you have headaches with exercise?	☐	☐	☐
Have you ever had numbness, tingling or weakness in your arms or legs after being hit or failing?	☐	☐	☐
Do you have a chronic illness or see another physician regularly for any particular problem?	☐	☐	☐
Do you take any prescribed medicine, herbs, or natural supplements?	☐	☐	☐
Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐	☐
Do you have any rashes, pressure sores, or other skin problems?	☐	☐	☐
Do you only have one of any paired organs? (Eyes, ears, kidneys, testicles, ovaries, etc.)	☐	☐	☐
Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐	☐
Have you ever been hospitalized overnight or had surgery?	☐	☐	☐
Have you ever had infectious mononucelosis (mono) within the last month?	☐	☐	☐
Do you wear glasses or contact lenses?	☐	☐	☐
Are you happy with your weight?	☐	☐	☐
Are you trying to gain or lose weight?	☐	☐	☐

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	YES	NO	DON'T KNOW
Has anyone recommended you change your weight or eating habits?	☐	☐	☐
Do you limit or carefully control what you eat?	☐	☐	☐
Do you have any concerns that you would like to discuss with the doctor?	☐	☐	☐
Females Only			
Have you ever had a menstrual period?	☐	☐	☐
How old were you when you had your first menstrual period?	☐	☐	☐
How many periods have you had in the last 12 months?	_____		

I hereby state that, to the best of my knowledge, my answers to the above question are complete and correct.

_____ _____

Signature Parent/Guardian Date