Sports / Activity / School Medical History Questionnaire

☐ PrimeCare of Kernersville
111 Gateway Center Drive
Kernersville, NC 27284
336/ 996-2173 Family Medicine
336/ 996-2379 Occupational
336/ 996-3254 FAX

☐ PrimeCare of Hickory Branch
501 Hickory Branch Road
Greensboro, NC 27409
336/ 878-2260 Family Medicine
336/ 878-2264 Occupational
336/ 878-2277 FAX

☐ PrimeCare of Highland Oaks
600 Highland Oaks Drive
Winston-Salem, NC 27103
336/ 774-0040 Family Medicine
336/ 774-0044 Occupational
336/ 774-0029 FAX

☐ PrimeCare of North Point
7811 North Point Blvd
Winston-Salem, NC 27106
336/ 759-0700 Family Medicine
336/ 896-1616 Occupational
336/ 759- 2226 FAX

☐ PrimeCare of Greensboro
3833 High Point Road
Greensboro, NC 27407
336/ 852-7530 Family Medicine
336/ 852-7050 Occupational
336/ 854-9682 FAX

To be completed by parent / guardian and athlete

NAME: _____ **MALE / FEMALE: (circle one)**

DATE OF BIRTH: _____ **AGE:** _____

ADDRESS: _____ **GRADE:** _____

_____ **Circle the sport(s) you plan to play:**

PHONE: _____

Baseball	Basketball
Cheerleading	Cross-country
Field Hockey	Football
Soccer	Softball
Swimming	Tennis
Track	Volleyball
Wrestling	Other: _____

Athlete's Directions: **Please review all questions with your parent or guardian and answer them to the best of your knowledge.**

Physician's Directions: **Please repeat the questions below to the patient reviewing details of positive answers.**

YES	NO	DON'T KNOW		
☐	☐	☐	**(1)**	Has anyone in the athlete's family (mother, father, brother, sister, etc.) died suddenly before age 50 years?
☐	☐	☐	**(2)**	Has the athlete ever stopped exercising because of dizziness or passed out during exercise?
☐	☐	☐	**(3)**	Does the athlete have wheezing or asthma, hay fever, or coughing spells after exercising?
☐	☐	☐	**(4)**	Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint?
☐	☐	☐	**(5)**	Does the athlete have a history of concussion (getting knocked out)?
☐	☐	☐	**(6)**	Has the athlete ever experienced a heat-related illness (heat stroke)?
☐	☐	☐	**(7)**	Does the athlete have anything he/she wants to talk to the doctor about?
☐	☐	☐	**(8)**	Does the athlete have a chronic illness or see a doctor regularly for any health problems?
☐	☐	☐	**(9)**	Does the athlete take any medication? Name: _____
☐	☐	☐	**(10)**	Is the athlete allergic to any medications, foods, or bee stings?
☐	☐	☐	**(11)**	Does the athlete have only one paired organ? (Eyes, Ears, Kidneys, Testicles, Ovaries, etc)
				FOR FEMALE ATHLETES: (Age 13 and older)
☐	☐	☐	**(12)**	Your age during first menstrual period? _____ years
☐	☐	☐	**(13)**	Are your menstrual periods regular every month? ☐ Yes ☐ No

Please comment on positive answers: _____

I have reviewed the above questions with my son or daughter, and I give permission for my child to undergo the Pre-participation Physical Evaluation and to participate in sports.

Signature of Parent or Guardian: _____ Date: ____/____/____

If limited English proficient or hearing impaired, offer interpreter at no additional cost::

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

NOVANT HEALTH

Sports / Activity / School Medical History Questionnaire

78275 R 03/18/2013

Name / MR # / Label