

LOMPOC HIGH SCHOOL
ATHLETICS

"Home of the Braves"
Pre-Participation Athletic Evaluation - History

**Please be advised that this is a pre-participation screening physical exam and in no way constitutes a complete medical physical examination.

NAME _____ Date of Birth _____
 Date of laast Tetanus Booster Shot _____
 Reaction to any Medicines _____
 Name of Family Physician _____

Answer the following questions by indicating: YES or NO.
 Has anyone in your IMMEDIATE FAMILY ever had the following:

- | | | |
|--|-----|----|
| Diabetes (high blood sugar in blood) | Yes | No |
| Allergies (hay fever or asthma) | Yes | No |
| Migraine Headaches | Yes | No |
| Heart Trouble | Yes | No |
| High blood pressure | Yes | No |
| Has anyone in your family, under age 50, died suddenly | Yes | No |

Have you been under a doctor's care in the last 12 months? Yes No

Have you been in the hospital in the last 12 months? Yes No

Have you ever had any type of surgery? Yes No

Do you want to talk to a doctor about a health problems or injury? .. Yes No

Have you had or do you now have and of the following? Yes No

- | | | |
|--|-----|----|
| Brain concussion (Head injury) | Yes | No |
| Skull Fracture | Yes | No |
| Convulsions or epilepsy | Yes | No |
| Neck or Back Injury | Yes | No |
| Very bad (impaired) vision in one eye | Yes | No |
| Temporary loss of vision | Yes | No |
| Wear glasses or contact lenses | Yes | No |
| Hearing Loss | Yes | No |
| Perforated eardrum | Yes | No |
| Discharge from ear(s) (recurrent infections) | Yes | No |
| Dental plate (dentures) orthodontia (teeth straightened) | Yes | No |