



Utah Valley Pediatrics Adolescent Health Evaluation

Date of Exam: _____ School: _____ Grade: _____
 Concerns: _____

Extra Curricular Activities: _____

	YES	NO		YES	NO
Have you had a medical illness or injury since your last check up or physical?			Do you have seasonal allergies (hay fever) that require medical treatment?		
Have you ever been hospitalized overnight? If yes, why?			Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (knee brace, neck roll, foot orthotics, dental retainer, hearing aid)?		
Are you currently taking any prescription or over the counter medications? Or are you using an inhaler?			Have you had any problems with your eyes or vision?		
Have you ever passed out during or after exercise?			Do you wear glasses, contacts or protective lenses?		
Have you ever been dizzy during exercise?			Have you ever had a sprain, strain or swelling after an injury?		
Have you ever had chest pain during exercise?			Have you broken or fractured any bones or dislocated any joints?		
Do you get more tired than your friends do during exercise?			Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? If yes, where?		
Have you ever had a "racing" heartbeat or "skipped" beats?			Do you want to weigh more or less than you do now?		
Have you had high blood pressure or high cholesterol?			Do you lose weight regularly to meet weight requirements for your sport?		
Have you ever been told that you have a heart murmur?			During the past month, have you often been bothered by feeling down, depressed or hopeless?		
Has any family member or relative died of heart problems or sudden death before age 50?			Do you have feelings of worthlessness?		
Have you had a severe viral infection (myocarditis or mononucleosis) within the last month?			During the past month, have you often been bothered by little interest or pleasure in doing things?		
Has a physician ever denied or restricted your participation in sports for any heart problems?			Do you feel agitated or restless?		
Do you have any current skin problems (itching, rashes, warts, fungus or blisters)?			Do you have disturbing thoughts about death?		
Have you ever had a head injury or concussion?			Do you feel persistently sad?		
Have you ever been knocked our, become unconscious or lost your memory?			Do you feel anxious or worried?		
Have you ever had a seizure?			FEMALES ONLY	YES	NO
Do you have frequent or severe headaches?			When was your first menstrual period?		
Have you ever had numbness or tingling in your arms, hands, legs or feet?			Do you have any menstrual or gynecological problems?		
Have you ever had a stinger, burner or pinched nerve?			When was your most recent menstrual period?		
Have you ever become ill from exercising in the heat?			How much time do you usually have from the start of one period to the start of another?		
Do you cough, wheeze, or have trouble breathing during or after activity?			How many periods have you had in the last year?		
Do you have asthma?			What was the longest time between periods in the last year?		

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

Signature of Patient _____ Signature of Parent/Guardian _____ Date _____

