

**Xtreme Intensive Wrestling Camp**  
**ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM**  
**HEALTH HISTORY QUESTIONNAIRE**  
**(To be completed by the parent and student)**

Today's Date: \_\_\_\_\_

Date of Last Physical: \_\_\_\_\_

Athlete's Name: \_\_\_\_\_ Sex: M F (circle one) Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sport: **WRESTLING** Home Phone: \_\_\_\_\_

Grade: \_\_\_\_\_ School: \_\_\_\_\_ District: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name: \_\_\_\_\_ Relationship to athlete: \_\_\_\_\_  
 Phone (work): \_\_\_\_\_ Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to athlete: \_\_\_\_\_  
 Phone (work): \_\_\_\_\_ Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_

**Directions:** Please answer the following questions about the student's medical history. Explain all "yes" responses at the bottom of the page. Please respond to all questions.

1. Have you had or do you currently have:

- |   |                    |
|---|--------------------|
| a. A sports physical within the past 365 days?                                      | Y / N / Don't Know |
| b. An injury or illness since your last exam?                                       | Y / N / Don't Know |
| c. A chronic or ongoing illness (such as diabetes or asthma)?                       | Y / N / Don't Know |
| 1. Use an inhaler or other prescription medicine to control asthma?                 | Y / N / Don't Know |
| d. Any prescribed or over the counter medications that you take on a regular basis? | Y / N / Don't Know |
| e. Surgery, hospitalization or any emergency room visit(s)?                         | Y / N / Don't Know |
| f. Any allergies to medications?  | Y / N / Don't Know |
| g. Any allergies to bee stings, pollen, latex or foods?                             | Y / N / Don't Know |
| 1. Type of reaction: Rash? Hives? Other skin condition? (Circle all that apply.)    | Y / N / Don't Know |
| 2. Take any medication/Epipen taken for allergy symptoms? (List below.)             | Y / N / Don't Know |
| h. Any anemias or blood disorders?  | Y / N / Don't Know |

2. Have you had or do you currently have any of the following *head-related* conditions since your last physical:

- |   |                    |
|---|--------------------|
| a. Concussion requiring a physician's evaluation? | Y / N / Don't Know |
| 1. How often and when? (Answer below.)            |                    |
| b. Memory loss or been knocked out?               | Y / N / Don't Know |
| c. A seizure?                                     | Y / N / Don't Know |
| d. Frequent or severe headaches?                  | Y / N / Don't Know |

3. Have you had or do you currently have any of the following *heart-related* conditions since your last physical:

- |   |                    |
|---|--------------------|
| a. Chest pain?  | Y / N / Don't Know |
| b. Heart murmur?  | Y / N / Don't Know |
| c. High blood pressure or elevated cholesterol level?   | Y / N / Don't Know |
| d. Restriction from sports for heart problems?          | Y / N / Don't Know |
| e. Any family member or relative:                       |                    |
| 1. Die of a heart problem before age 35?                | Y / N / Don't Know |
| 2. Die of a heart problem before age 50?                | Y / N / Don't Know |
| 3. Die with no known reason?                            | Y / N / Don't Know |
| 4. Die while exercising? During or after? (Circle one.) | Y / N / Don't Know |
| 5. With Marfan's Syndrome?                              | Y / N / Don't Know |

4. Have you had or do you currently have any of the following *eye, ear, nose, mouth or throat conditions* since your last physical:
- a. Vision problems? Y / N / Don't Know
    - 1. Wear contacts, eyeglasses or protective eye wear? (Circle which type.) Y / N / Don't Know
  - b. Hearing loss or problems? Y / N / Don't Know
    - 1. Wear hearing aides or implants? Y / N / Don't Know
  - c. Nasal fractures or frequent nose bleeds? Y / N / Don't Know
  - d. Wear braces, retainer or protective mouth gear? Y / N / Don't Know
  - e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? Y / N / Don't Know
5. Have you had or do you currently have any of the following *neuromuscular/orthopedic conditions* since your last physical:
- a. A burner, stinger or pinched nerve? Y / N / Don't Know
  - b. A sprain? Y / N / Don't Know
  - c. A strain? Y / N / Don't Know
  - d. Swelling or pain in muscles, tendons, bones or joints? Y / N / Don't Know
  - e. A dislocated joint(s)? Y / N / Don't Know
  - f. Upper or lower back pain? Y / N / Don't Know
  - g. Fracture(s) or stress fracture(s)? Y / N / Don't Know
  - h. Do you wear any protective braces or equipment for any prior injury? Y / N / Don't Know
6. Have you had or do you currently have any of the following *general or exercise related conditions* since your last physical:
- a. Difficulty breathing? During Exercise? (Circle one.)
    - 1. After running one mile Y / N / Don't Know
    - 2. Coughing, wheezing or shortness of breathe in weather changes? Y / N / Don't Know
    - 3. Exercise-induced asthma Y / N / Don't Know
      - i. Controlled with medication? (List below.) Y / N / Don't Know
      - ii. Experience dizziness, passing out or fainting? Y / N / Don't Know
  - b. Viral infections (e.g. mono, hepatitis)? Y / N / Don't Know
  - c. Become tired more quickly than your friends? Y / N / Don't Know
  - d. Any of the following skin conditions:
    - 1. Acne, contact dermatitis, ringworm, warts, herpes? Y / N / Don't Know
    - 2. Sun sensitivity? Y / N / Don't Know
  - e. Weight gain/loss (greater than or less than 10 pounds)? Y / N / Don't Know
    - 1. Do you want to weigh more or less than you do now? Y / N / Don't Know
  - f. Ever had feelings of depression? Y / N / Don't Know
  - g. Heat-related problems (dehydration, dizziness, fatigue, headache)? Y / N / Don't Know
    - 1. Heat exhaustion (cool, clammy, damp skin)? Y / N / Don't Know
    - 2. Heat stroke (hot, red, dry skin)? Y / N / Don't Know
7. **Females only:**  
 Age of onset of menstruation: \_\_\_\_\_  
 Date of last menstruation: \_\_\_\_\_  
 Most number of days between menstruation cycle(s): \_\_\_\_\_

**Explain all (yes) answers here (include relevant dates):**

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I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_