

**ARIZONA PROJECT CHALLENGE
PHYSICAL EXAMINATION FORM
Part A: HEALTH HISTORY QUESTIONNAIRE**

(To be completed by the parent)
(This information must be completed or this form will be returned)

Date: _____

Date of Last Physical: _____

Applicant's Name: _____ Sex: M F (Circle One)

Age: _____ Date of Birth: _____ Home Phone #: _____

Other Phone #: _____ Physician: _____

Physician Phone#: _____ Fax #: _____

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
 - Use an inhaler or other prescription medicine to control asthma? Y / N/ Don't know
 - d. Any prescribed or over the counter medication that you take on a regular basis? Y / N/ Don't know
 - e. Surgery, hospitalization or any emergency room visits? Y / N/ Don't know
 - f. Any allergies to medication? Y / N/ Don't know
 - g. Any allergies to bee stings, pollen, latex, or foods? Y / N/ Don't know
 - Type or reaction: Rash? Hives? Other skin condition? (circle)
 - Medication for reaction? (List) _____
 - h. Any anemia or blood disorders? Y / N/ Don't know
2. Have you had or do you currently have any of the following *head-related* conditions:
 - a. Concussion requiring a physician's evaluation? Y / N/ Don't know
 - How often and when? _____
 - 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:
 - 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:
 - Die of a heart problem before age 35? Y / N/ Don't know
 - Die of a heart problem before age 50? Y / N/ Don't know
 - Die with no known reason? Y / N/ Don't know
 - Die while exercising? During or after? (circle one) Y / N/ Don't know
 - With Marfan's Syndrome? (connective tissues disorder) 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:
 - a. Vision problem? Y / N/ Don't know
 - Wear contact, eyeglasses or protective eye wear? (circle one) Y / N/ Don't know
 - b. Hearing loss or problems? Y / N/ Don't know
 - 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:
 - 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:
 - a. Difficulty breathing? During exercise? (circle) Y / N/ Don't know
 - After running on mile? Y / N/ Don't know
 - Coughing, wheezing or shortness of breather in weather changes? Y / N/ Don't know
 - Exercise-induced asthma Y / N/ Don't know
 - Controlled with medication? List _____ Y / N/ Don't know
 - 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?
 - Acne, contact dermatitis, ringworm, warts, herpes? Y / N/ Don't know
 - Sun sensitivity? Y / N/ Don't know
 - e. Weight gain/loss (greater than or less than 10 lbs)? Y / N/ Don't know
 - Do you want to weight more or less then you do now? M / L
 - f. Ever had feelings of depression? Y / N/ Don't know
 - g. Psychiatric diagnosis? Y / N/ Don't know
 - h. Inpatient psychiatric facility? Y / N/ Don't know
 - i. Heat-related problems (dehydration, dizziness, fatigue, headache)? Y / N/ Don't know
 - Heat exhaustion (cool, clammy, damp skin)? Y / N/ Don't know
 - Heat stroke (hot, red, dry skin)? Y / N/ Don't know

7. **FEMALES ONLY:**

- a. Age on onset of menstruation: _____
- b. Date of last menstruation: _____
- c. Most number of days between menstruation cycle (s): _____

Explain all YES answers here (include relevant dates):

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature. **Lying or withholding information on this questionnaire could result in your child's termination from the program.**

Parent/Guardian Signature: _____ Date: _____