



CIGNA HealthCare of Arizona

CIGNA Medical Group

NAME

MR #

DOB

(Member Information)

C.L. _____

Pediatric Sports Physical History

DATE: _________	YES	NO
1. Do you take any medication, pills, or supplements?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have diabetes, asthma, allergies (<i>hay fever</i>), or any chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been admitted to a hospital or had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a injury that required an operation or caused you to miss 3 days of practice or competition?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had a concussion?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been dizzy, developed a headache, or passed out during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you unable to run 2 times around the track without stopping?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have any members of your family under the age of 50 had a heart attack, heart problems, or died unexpectedly?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had a heart murmur, high blood pressure, or heart abnormality?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you wear glasses, contacts, prosthesis, or dental bridges, plates or braces?	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you missing a kidney?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you had chickenpox? When? _____	<input type="checkbox"/>	<input type="checkbox"/>
14. For Women: How old were you when you started periods? _____		
14a. In the last year, what is the longest time you have gone between periods? _____		
15. What sport(s) are you planning to participate in? _____		

PLEASE EXPLAIN ANY **YES** ANSWERS:

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

Signature of patient: _____ Date: _____

Signature of parent/guardian: _____ Date: _____