

MEDICAL HISTORY FORM

Student Name: _____ Date of Birth: _____

The Medical History Form is part of the Athletic Physical and must be presented to the physician at the time of the physical examination.
 Explain "Yes" answers at end of form. Circle questions for which you don't know the answers.

The student with the help of the parent or guardian is to answer the following questions:

1. Have you had a medical illness or injury since your last check up or sports physical? Yes__ No__
2. Have you been hospitalized overnight in the past year? Yes__ No__
 Have you had surgery in the past year? Yes__ No__
3. Are you currently taking any prescriptions or non-prescription (over the counter) medication or pills or using an inhaler? Yes__ No__
4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)? Yes__ No__
5. Have you ever passed out during or after exercise? Yes__ No__
 Have you ever been dizzy during or after exercise? Yes__ No__
 Have you ever had chest pain during or after exercise? Yes__ No__
 Do you get tired more quickly than your friends during exercise do? Yes__ No__
 Have you ever had racing of your heart or skipped heartbeats? Yes__ No__
 Have you ever been told you have a heart murmur? Yes__ No__
 Has any family member or relative died of heart problems or of sudden unexpected death before age 50? Yes__ No__
 Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm? Yes__ No__
 Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Yes__ No__
 Has a physician ever denied or restricted your participation in sports for any heart problems? Yes__ No__
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? Yes__ No__
7. Have you ever had a head injury or concussion? Yes__ No__
 Have you ever been knocked out, become unconscious, or lost your memory? Yes__ No__
 If yes, how many times? ____ When was the last concussion? _____ Yes__ No__
 How severe was each one? (Explain in the space provided) Yes__ No__
 Have you ever had a seizure? Yes__ No__
 Do you have frequent or severe headaches? Yes__ No__
 Have you ever had numbness or tingling in your arms, hands, legs or feet? Yes__ No__
 Have you ever had a stinger, burner, or pinched nerve? Yes__ No__
8. Have you ever become ill from exercising in the heat? Yes__ No__
9. Have you ever gotten unexpectedly short of breath with exercise? Yes__ No__
 Do you cough, wheeze, or have trouble breathing during or after activity? Yes__ No__
 Do you have asthma? Yes__ No__
 Do you have seasonal allergies that require medical treatment? Yes__ No__
10. Have you had any problems with your eyes or vision? Yes__ No__
11. Are you missing any paired organs? Yes__ No__
12. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, and retainer on your teeth, hearing aid?) Yes__ No__

MEDICAL HISTORY FORM – PART 2

Student Name: _____ Date of Birth: _____

- 13. Have you ever had a sprain, strain, or swelling after injury? Yes ___ No ___
- Have you broken or fractured any bones or dislocated any joints? Yes ___ No ___
- Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? Yes ___ No ___

If yes, check the appropriate one and explain below.

- | | | |
|------------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh |
| <input type="checkbox"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Shin/Calf |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Foot | |

- 14. Do you want to weigh more or less than you do now? Yes ___ No ___
- Do you lose weight regularly to meet weight requirements for your sport? Yes ___ No ___
- 15. Do you feel stressed out? Yes ___ No ___

- 16. Record the dates of your most recent immunizations (shots) or disease for:
- Tetanus _____ Measles _____
- Hepatitis B _____ Chickenpox _____

- 17. Are you currently under a doctor's care?

FOR FEMALES ONLY:

- 18. When was your first menstrual period? _____
- What was your most recent menstrual period? _____
- How much time do you usually have from the start of one period to the start of another? _____
- How many periods have you had in the last year? _____
- What was the longest time between periods in the last year? _____

Explain "Yes" answers here:

Please list all prescribed medication taken by your child:

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

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

I have reviewed and acknowledge the information in this Medical History Form.

Physician's or Authorized Examiner's Signature: _____ Date: _____