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 do during exercise?	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.

_____ Head	___ Elbow	____ Hip
_____ Neck	___ Forearm	____ Thigh
_____ Back	___ Wrist	____ Knee
_____ Chest	___ Hand	____ Shin/Calf
_____ Shoulder	___ Finger	____ Ankle
_____ Upper Arm		____ 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: _____