BETHANY
CHRISTIAN SCHOOL

Department of Athletics and Sports
Student - Athlete Medical History Questionnaire

Last Name:_____ First: _____

Sport:_____ Year: 20____ - 20____

Date of Birth:_____ Male:___ Female:___

Cell Phone #:_____

I. <u>Specific Medical Questions</u>

1. Have you ever had any SURGERY? YES NO

Date_____ Injury/Illness_____

2. Are you presently taking any prescribed medication(s) (including inhalers, ADHD medications, etc.)? YES NO

If YES, please indicate name of drug, reason and usual dosage:

_____

_____

_____

II. ALLERGIES

1. Are you allergic to any medications? **YES** **NO**

(PLEASE LIST) _____

2. Are you allergic to any insect bites? **YES** **NO**

(PLEASE LIST) _____

3. Do you have any other allergies? **YES** **NO**

(PLEASE LIST) _____

III. ILLNESS

1. Have you suffered from or have	**Diabetes:**	**Y**	**N**
been told by a physician you have	**Epilepsy:**	**Y**	**N**
had or do have the following:	**Chronic Fatigue:**	**Y**	**N**

2. Do you have any type of blood disorder (anemia, etc)? **Y** **N**
If yes, please explain:

IV. CARDIOPULMONARY

1. Do you have asthma or ever been treated for an asthma attack? **YES** **NO**

If yes, do you carry or use an inhaler when you participate in sports? **YES** **NO**

2. Have you ever:

A. ...been told you have a heart murmur or any other heart condition? If YES, specify date: **YES NO**

_____

B. ...been held from competition for a heart condition? **YES NO**

C. ...experienced an "irregular" heartbeat, dizziness, or chest pain with exercise? **YES NO**

3. Have you ever fainted, passed out, or blacked out during exercise? If yes, please explain: **YES NO**

_____

_____

V. <u>Nose</u>

Do you get nosebleeds? If yes, please explain: **YES NO**

_____

_____

VI. <u>Head and Neck</u>

1. Have you ever suffered a concussion or head injury or been knocked unconscious? If yes, please explain: **YES NO**

_____

_____

2. Do you suffer headaches (migraine or frequent)? YES NO

If yes, please explain: _____

_____

3. Have you ever had a neck injury? YES NO

If yes, please explain: _____

_____

4. Any other injuries please list (shoulder, leg, etc)? YES NO

If yes, please explain: _____

_____

VII. Other

1. Do you wear orthotics in athletic shoes? YES NO

2. Ever suffer heat stroke or exhaustion? YES NO

3. Any additional information regarding any concerns or medical or personal, please let us know.

_____

_____

_____

IMPORTANT NOTE: If you have been seen by a medical professional for any major or serious injuries or illnesses, PLEASE obtain and send copies of all office visit notes, any physical therapy notes, and/or tests done.

PLEASE make sure you have had your annual physical. Any delay in medical documentation may delay participation in athletics at Bethany Christian School.

I, understand, hereby acknowledge, affirm, and represent that all statements and answers on this questionnaire are true and accurate to the best of my knowledge.

_____ _____

Student-Athlete Signature **Date**

_____

Print Student-Athlete Name

_____ _____

Parent Signature **Date**

_____

Print Parent Name