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. Specific Medical Questions
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 been told by a physician you have had or do have the following:
   - Diabetes: YES NO
   - Epilepsy: YES NO
   - Chronic Fatigue: YES NO

2. Do you have any type of blood disorder (anemia, etc)? YES NO
   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:  
      ______________________
   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:
   ______________________________________________________
   ______________________________________________________

V. Nose

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

VI. Head and Neck

1. Have you ever suffered a concussion or head injury or been knocked unconscious? If yes, please explain:
   ______________________________________________________
   ______________________________________________________
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