

Health History

To Be Completed By Student And/Or Parent

HISTORY

Name: _____ Date: _____ Phone: _____

Personal Physician: _____ Sex: M F Age: _____

Please explain "yes" answers below:

- | | | |
|--|------------------------------|-----------------------------|
| 1. Have you ever been hospitalized? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Have you ever had surgery? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Are you presently taking any medications or pills? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Do you have any allergies (medicine, bees, or other stinging insects)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Have you ever passed out during or after exercise? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Have you ever had chest pain during or after exercise? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Do you tire more quickly than your friends during exercise? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Have you ever had high blood pressure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Have you ever been told that you have a heart murmur? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Have you ever had a racing of your heart or skipped heartbeats? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Has anyone in your family died of heart problems or a sudden death before age 50? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Do you have any skin problems (itching, rashes, acne)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Have you ever had a head injury? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Have you ever been knocked out or unconscious? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Have you ever had a seizure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Have you ever had a stinger, burner or pinched nerve? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 18. Have you ever had heat or muscle cramps? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 19. Have you ever been dizzy or passed out in the heat? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 20. Do you have trouble breathing or do you cough during or after activity? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 21. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 22. Have you had any problems with your eyes or vision? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 23. Do you wear glasses, contacts or protective eye-wear? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 24. Have you ever sprained/strained, dislocated, fractured, broken or had repeated or other injuries of any bones or joints? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Head <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Neck <input type="checkbox"/> Knee <input type="checkbox"/> Hand
<input type="checkbox"/> Forearm <input type="checkbox"/> Thigh <input type="checkbox"/> Wrist <input type="checkbox"/> Hip <input type="checkbox"/> Foot
<input type="checkbox"/> Shoulder <input type="checkbox"/> Back <input type="checkbox"/> Elbow <input type="checkbox"/> Chest | | |
| 25. Have you had any other medical problem (infectious mononucleosis, diabetes, etc.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 26. Have you had a medical problem or injury since your last evaluation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 27. When was your last tetanus shot? | | _____ |
| 28. When was your last measles immunization? | | _____ |
| 29. When was your first menstrual period? | | _____ |
| 30. When was your last menstrual period? | | _____ |
| 31. What was the longest time between your periods last year? | | _____ |

Please explain "yes" answers: _____

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

Signature of Athlete _____ Date _____

Signature of Parent/Guardian _____ Date _____