Medical History

Date ________________ Name ___________________________________Sport(s)______________________
SS# ________________ Date of Birth ______________ Sex ____________ Year in School Fr So Jr Sr

PLEASE ANSWER THE FOLLOWING QUESTIONS IN AS MUCH DETAIL AS POSSIBLE.
Please check the appropriate box. Explain **YES** answers in space provided.

Have you ever:	Y	N	Comments
Been hospitalized or had any surgery?	( )	( )	____________
Broken a bone, or had a muscle injury?	( )	( )	____________
Been treated for a severe viral infection in the last year? (Ex. Mono, myocarditis, etc)	( )	( )	____________
Has anyone in your immediate family ever had:			
Sudden death (age less than 50)?	( )	( )	____________
High blood pressure?	( )	( )	____________
Diabetes (high blood sugar)?	( )	( )	____________
Heart attack (age less than 50)?	( )	( )	____________
High cholesterol?	( )	( )	____________
Asthma?	( )	( )	____________
Have you ever had or do you now have:			
Chest pain with or after exercise?	( )	( )	____________
Dizziness with or after exercise?	( )	( )	____________
Passed out with exercise?	( )	( )	____________
Racing of the heart/irregular rhythm?	( )	( )	____________
Heart murmur?	( )	( )	____________
High blood pressure?	( )	( )	____________
Diabetes (high blood sugar)?	( )	( )	____________
High cholesterol?	( )	( )	____________
Sickle cell anemia or sickle cell trait?	( )	( )	____________
Have you ever had or have now:			
Cough/wheezing with exercise, asthma?	( )	( )	____________
Weakness, fatigue, or anemia?	( )	( )	____________
Use an inhaler?	( )	( )	____________
Have you had or do you now have:			
Headaches or migraines?	( )	( )	____________
Hearing loss or perforated eardrum?	( )	( )	____________
Dental plate or orthodontic work?	( )	( )	____________
Impaired vision, wear glasses/contacts?	( )	( )	____________
Unequal pupils?	( )	( )	____________
Hernia?	( )	( )	____________
Numbness/tingling in any limb(s)	( )	( )	____________
Weight problem (or recent weight gain/loss)	( )	( )	____________

Date of last tetanus shot: ____

List any current medications: (prescription or nonprescription example: acne, birth control, vitamins, supplements)

____

List any allergies: ____

Have you ever had:	Y	N	Comments
Concussion?	( )	( )	______________________
Loss of consciousness?	( )	( )	______________________
Convulsions (seizures) or epilepsy?	( )	( )	______________________
Stress Fracture?	( )	( )	Where, location, and treatment: ________
			______________________
Have you ever had a neck injury of any kind?	( )	( )	If Yes, type of injury? ____________
Have you ever had any back injury/pain?	( )	( )	______________________
If yes, location, dates.			______________________
Any special x-rays?	( )	( )	______________________
Did you undergo rehabilitation?	( )	( )	______________________
Have you ever sustained a shoulder injury?	( )	( )	______________________
If yes, indicate type of injury, shoulder, dates.			______________________
Did you have surgery?	( )	( )	If Yes, when?________________
Did you undergo rehabilitation?	( )	( )	______________________
Have you ever sustained a knee injury?	( )	( )	______________________
If yes, indicate type of injury, knee and dates.			______________________
Did you have surgery?	( )	( )	If Yes, when?________________
Did you undergo rehabilitation?	( )	( )	______________________
Have you ever sprained your ankle?	( )	( )	______________________
If yes, indicate type of injury, ankle, and dates.			______________________
Did you have surgery?	( )	( )	If Yes, when? ________________
Did you undergo rehabilitation?	( )	( )	______________________
Have you ever worn a special brace, or had modifications made in equipment worn?	( )	( )	If Yes, indicate reason.____________
Have you ever been treated for any medical or physical condition not mentioned?	( )	( )	______________________
Males:			
Do you have a loss of function or absence of testicles or any other related problem?	( )	( )	______________________
Females:			
Do you have a menstrual cycle?	( )	( )	
Age of onset of menstruation:			______________________
Have you had or do you now have menstrual irregularities or absence of menses?	( )	( )	______________________

I attest that the above information is correct and complete to my knowledge.

Athlete's Signature ______________________________ **Date** ____________

Parent/Guardian Signature ______________________________ **Date** ____________

(If athlete is under 18 years of age)