



# Athletic Medical History

2009 - 2010

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sport(s) \_\_\_\_\_  
 Parent/guardian \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Parent/guardian Address \_\_\_\_\_

### Any YES answers require written explanation!

- |   | Yes                      | No                       |   | Yes                              | No                                 |
|---|--------------------------|--------------------------|---|----------------------------------|------------------------------------|
| 1. Have you had a medical illness or injury since your last doctor's check up or sports physical?               | <input type="checkbox"/> | <input type="checkbox"/> | 10. Have you had a severe viral infection (i.e. myocarditis or mono) within the last year?                        | <input type="checkbox"/>         | <input type="checkbox"/>           |
| Do you have an ongoing or chronic illness?  | <input type="checkbox"/> | <input type="checkbox"/> | Have you been diagnosed with Hepatitis, HIV or sickle cell?   | <input type="checkbox"/>         | <input type="checkbox"/>           |
| 2. Have you ever been hospitalized overnight?   | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been diagnosed or treated for tuberculosis?   | <input type="checkbox"/>         | <input type="checkbox"/>           |
| Have you ever had surgery?  | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you had any problems with your eyes or vision?   | <input type="checkbox"/>         | <input type="checkbox"/>           |
| Has a physician ever denied or restricted your participation in sports?   | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear glasses, contacts or protective eyewear (while playing sports)?                                       | <input type="checkbox"/>         | <input type="checkbox"/>           |
| 3. Do you lose weight regularly to meet weight requirements for your sport?                                     | <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you use any protective or corrective equipment (i.e. knee brace, foot orthotics, retainer or hearing aid)? | <input type="checkbox"/>         | <input type="checkbox"/>           |
| Do you want to weigh more or less than you do right now?  | <input type="checkbox"/> | <input type="checkbox"/> | Do you have a pin, screw or plate somewhere in your body as a result of bone or joint injury?                     | <input type="checkbox"/>         | <input type="checkbox"/>           |
| Have you ever taken any supplements or vitamins to help you gain or lose weight or to improve your performance? | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a sprain, strain or swelling after an injury?   | <input type="checkbox"/>         | <input type="checkbox"/>           |
| <b>LIST:</b>  | <input type="checkbox"/> | <input type="checkbox"/> | Have you broken or fractured (including stress fracture) any bones or dislocated any joints?                      | <input type="checkbox"/>         | <input type="checkbox"/>           |
| 4. Do you have any current skin problems (for example, itching, rashes, warts, fungus or blisters)?             | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?                       | <input type="checkbox"/>         | <input type="checkbox"/>           |
| Do you develop rashes or hives during or after exercise?  | <input type="checkbox"/> | <input type="checkbox"/> | <b>If yes, check appropriate box and explain below.</b>   |                                  |                                    |
| 5. Have you ever passed out during or after exercise?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Head   | <input type="checkbox"/> Elbow   | <input type="checkbox"/> Hip       |
| Have you ever been dizzy during or after exercise?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Neck   | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh     |
| Have you ever had chest pain during or after exercise?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Back   | <input type="checkbox"/> Wrist   | <input type="checkbox"/> Knee      |
| Have you ever become ill from exercising in the heat?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Chest  | <input type="checkbox"/> Hand    | <input type="checkbox"/> Shin/calf |
| Have you had high blood pressure or high cholesterol?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Shoulder   | <input type="checkbox"/> Finger  | <input type="checkbox"/> Ankle     |
| 6. Have you ever been told you have a heart murmur?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Upper arm  | <input type="checkbox"/> Foot    |                                    |
| Have you ever had racing or skipped heartbeats?   | <input type="checkbox"/> | <input type="checkbox"/> | 13. Date of your last Tetanus shot:   |                                  |                                    |
| Has any relative died of heart problems or of sudden death before?  | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you cough, wheeze or have trouble breathing during or after?   | <input type="checkbox"/>         | <input type="checkbox"/>           |
| 7. Do you have frequent or severe headaches?  | <input type="checkbox"/> | <input type="checkbox"/> | Do you have asthma?   | <input type="checkbox"/>         | <input type="checkbox"/>           |
| Have you ever been knocked out, become unconscious or lost your memory?   | <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you have any allergic reactions to (i.e. pollen, medicine, food or insects)?                               | <input type="checkbox"/>         | <input type="checkbox"/>           |
| Have you ever had a head injury or a concussion?  | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any allergies that require medical treatment?   | <input type="checkbox"/>         | <input type="checkbox"/>           |
| 8. Have you ever had a seizure or been told you might have epilepsy?  | <input type="checkbox"/> | <input type="checkbox"/> | 16. Are you currently on any prescription or nonprescription  | <input type="checkbox"/>         | <input type="checkbox"/>           |
| 9. Have you ever had numbness or tingling in your arms, hands, legs or  | <input type="checkbox"/> | <input type="checkbox"/> |   |                                  |                                    |
| Have you ever had a stinger, burner or pinched nerve?   | <input type="checkbox"/> | <input type="checkbox"/> |   |                                  |                                    |

#### Females Only

When was your first menstrual period? \_\_\_\_\_  
 When was your most recent menstrual period? \_\_\_\_\_  
 How many periods have you had in the last year? \_\_\_\_\_

#### Please list any medications you are currently taking.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Explain all "Yes" answers in the lines below as well as any pertinent medical information not listed above.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please use the back of this paper if you need more space.

Signature of Athlete \_\_\_\_\_

Signature of Parent/Guardian (if student is under 18) \_\_\_\_\_

Date \_\_\_\_\_

Signature of Medical Professional \_\_\_\_\_

Date \_\_\_\_\_