

## MEDICAL HISTORY FORM

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

The Medical History Form is part of the Athletic Physical and must be presented to the physician at the time of the physical examination.

Explain "Yes" answers at end of form. Circle questions for which you don't know the answers.

The student, with the help of the parent or guardian, is to answer the following questions:

1. Have you had a medical illness or injury since your last check up or sports physical? Yes\_\_ No\_\_
2. Have you been hospitalized overnight in the past year? Yes\_\_ No\_\_  
Have you had surgery in the past year? Yes\_\_ No\_\_
3. Are you currently taking any prescriptions or non-prescription (over the counter) medication or pills or using an inhaler? Yes\_\_ No\_\_
4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)? Yes\_\_ No\_\_
5. Have you ever passed out during or after exercise? Yes\_\_ No\_\_  
Have you ever been dizzy during or after exercise? Yes\_\_ No\_\_  
Have you ever had chest pain during or after exercise? Yes\_\_ No\_\_  
Do you get tired more quickly than your friends do during exercise? Yes\_\_ No\_\_  
Have you ever had racing of your heart or skipped heartbeats? Yes\_\_ No\_\_  
Have you ever been told you have a heart murmur? Yes\_\_ No\_\_  
Has any family member or relative died of heart problems or of sudden unexpected death before age 50? Yes\_\_ No\_\_  
Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm? Yes\_\_ No\_\_  
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Yes\_\_ No\_\_  
Has a physician ever denied or restricted your participation in sports for any heart problems? Yes\_\_ No\_\_
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? Yes\_\_ No\_\_
7. Have you ever had a head injury or concussion? Yes\_\_ No\_\_  
Have you ever been knocked out, become unconscious, or lost your memory? Yes\_\_ No\_\_  
If yes, how many times? \_\_\_\_ When was the last concussion? \_\_\_\_\_ Yes\_\_ No\_\_  
How severe was each one? (Explain in the space provided) Yes\_\_ No\_\_  
Have you ever had a seizure? Yes\_\_ No\_\_  
Do you have frequent or severe headaches? Yes\_\_ No\_\_  
Have you ever had numbness or tingling in your arms, hands, legs or feet? Yes\_\_ No\_\_  
Have you ever had a stinger, burner, or pinched nerve? Yes\_\_ No\_\_
8. Have you ever become ill from exercising in the heat? Yes\_\_ No\_\_
9. Have you ever gotten unexpectedly short of breath with exercise? Yes\_\_ No\_\_  
Do you cough, wheeze, or have trouble breathing during or after activity? Yes\_\_ No\_\_  
Do you have asthma? Yes\_\_ No\_\_  
Do you have seasonal allergies that require medical treatment? Yes\_\_ No\_\_
10. Have you had any problems with your eyes or vision? Yes\_\_ No\_\_
11. Are you missing any paired organs? Yes\_\_ No\_\_
12. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, and retainer on your teeth, hearing aid?) Yes\_\_ No\_\_

MEDICAL HISTORY FORM – PART 2

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

13. Have you ever had a sprain, strain, or swelling after injury? Yes  No   
 Have you broken or fractured any bones or dislocated any joints? Yes  No   
 Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? Yes  No   
 If yes, check the appropriate one and explain below.

- |                                    |                                  |                                    |
|------------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> Head      | <input type="checkbox"/> Elbow   | <input type="checkbox"/> Hip       |
| <input type="checkbox"/> Neck      | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh     |
| <input type="checkbox"/> Back      | <input type="checkbox"/> Wrist   | <input type="checkbox"/> Knee      |
| <input type="checkbox"/> Chest     | <input type="checkbox"/> Hand    | <input type="checkbox"/> Shin/Calf |
| <input type="checkbox"/> Shoulder  | <input type="checkbox"/> Finger  | <input type="checkbox"/> Ankle     |
| <input type="checkbox"/> Upper Arm | <input type="checkbox"/>         | <input type="checkbox"/> Foot      |

14. Do you want to weigh more or less than you do now? Yes  No   
 Do you lose weight regularly to meet weight requirements for your sport? Yes  No   
 15. Do you feel stressed out? Yes  No

16. Record the dates of your most recent immunizations (shots) or disease for:  
 Tetanus \_\_\_\_\_ Measles \_\_\_\_\_  
 Hepatitis B \_\_\_\_\_ Chickenpox \_\_\_\_\_

17. Are you currently under a doctor's care?

FOR FEMALES ONLY:

18. When was your first menstrual period? \_\_\_\_\_  
 What was your most recent menstrual period? \_\_\_\_\_  
 How much time do you usually have from the start of one period to the start of another? \_\_\_\_\_  
 How many periods have you had in the last year? \_\_\_\_\_  
 What was the longest time between periods in the last year? \_\_\_\_\_

Explain "Yes" answers here:

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Please list all prescribed medication taken by your child:

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

Student Signature: \_\_\_\_\_  
\_\_\_\_\_

Date:

Parent/Guardian Signature: \_\_\_\_\_  
\_\_\_\_\_

Date:

I have reviewed and acknowledge the information in this Medical History Form.

Physician's or Authorized Examiner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_