Student's Name _____ Age_____ Grade_____

SECTION 5: HEALTH HISTORY

Explain "Yes" answers at the bottom of this form.
Circle questions you don't know the answers to.

		Yes	No
1	Has a doctor ever denied or restricted your participation in sport(s) for any reason?	❑	❑
2.	Do you have an ongoing medical condition (like asthma or diabetes)?	❑	❑
3	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	❑	❑
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	❑	❑
5	Have you ever passed out or nearly passed out DURING exercise?	❑	❑
6	Have you ever passed out or nearly passed out AFTER exercise?	❑	❑
7	Have you ever had discomfort, pain, or pressure in your chest during exercise?	❑	❑
8	Does your heart race or skip beats during exercise?	❑	❑
9	Has a doctor ever told you that you have (check all that apply) ❑ High blood pressure ❑ Heart murmur ❑ High cholesterol ❑ Heart infection	❑	❑
10	Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	❑	❑
11	Has anyone in your family died for no apparent reason?	❑	❑
12	Does anyone in your family have a heart problem?	❑	❑
13	Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?	❑	❑
14	Does anyone in your family have Marfan Syndrome?	❑	❑
15	Have you ever spent the night in a hospital?	❑	❑
16	Have you ever had surgery?		
17	Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, which caused you to miss a Practice or Contest? If yes, circle affected area below	❑	❑
18	Have you had any broken or fractured bones or dislocated joints? If yes, circle below	❑	❑
19	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below	❑	❑

Head Neck Shoulder Upper arm Elbow Forearm Hand/ Fingers Chest
Upper back Lower back Hip Thigh Knee Calf/shin Ankle Foot/ Toes

20	Have you ever had a stress fracture?	❑	❑
21	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	❑	❑
22	Do you regularly use a brace or assistive device?	❑	❑
23	Has a doctor ever told you that you have asthma or allergies?	❑	❑
24	Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	❑	❑
25	Is there anyone in your family who has asthma?	❑	❑
26	Have you ever used an inhaler or taken asthma medicine?	❑	❑
27	Were you born without or are your missing a kidney, an eye, a testicle, or any other organ?	❑	❑
28	Have you had infectious mononucleosis (mono) within the last month?	❑	❑
29	Do you have any rashes, pressure sores, or other skin problems?	❑	❑
30	Have you ever had a herpes skin infection?	❑	❑
	CONCUSSION OR TRAUMATIC BRAIN INJURY		
31	Have you ever had a concussion (i e bell rung, ding, head rush) or traumatic brain injury?	❑	❑
32	Have you been hit in the head and been confused or lost your memory?	❑	❑
33	Do you experience dizziness and/or headaches with exercise?	❑	❑
34	Have you ever had a seizure?	❑	❑
35	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	❑	❑
36	Have you ever been unable to move your arms or legs after being hit or falling?	❑	❑
37.	When exercising in the heat, do you have severe muscle cramps or become ill?	❑	❑
38	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	❑	❑
39	Have you had any problems with your eyes or vision?	❑	❑
40	Do you wear glasses or contact lenses?	❑	❑
41	Do you wear protective eyewear, such as goggles or a face shield?	❑	❑
42	Are you unhappy with your weight?	❑	❑
43	Are you trying to gain or lose weight?	❑	❑
44	Has anyone recommended you change your weight or eating habits?	❑	❑
45	Do you limit or carefully control what you eat?	❑	❑
46	Do you have any concerns that you would like to discuss with a doctor?	❑	❑
	MENSTRUAL QUESTIONS- IF APPLICABLE	❑	❑
47	Have you ever had a menstrual period?	❑	❑
48	How old were you when you had your first menstrual period?	_____	
49	How many periods have you had in the last 12 months?	_____	
50.	When was your last menstrual period?		

#'s	Explain "Yes" answers here:

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature _____ Date___/___/_____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent's/Guardian's Signature _____ Date___/___/_____