SPORTS PREPARTICIPATION MEDICAL HEALTH HISTORY

NAME: ______________________________ **DATE:** ____________________

ADDRESS: ______________________________ **PHONE:** ____________________

		YES	NO
1.	Have you had a medical illness or injury since your last physical?	____	____
2.	Do you have an ongoing or chronic illness?	____	____
3.	Have you ever been hospitalized overnight?	____	____
4.	Have you ever had surgery?	____	____
5.	Are you currently taking any prescription or non-prescription medications?	____	____
6.	Have you ever taken any vitamins/supplements to help you gain/lose weight?	____	____
7.	Do you have any allergies?	____	____
8.	Have you ever developed a rash or hives during or after exercise?	____	____
9.	Have you ever passed out during or after exercise?	____	____
10.	Have you ever been dizzy during or after exercise?	____	____
11.	Have you ever had chest pain during or after exercise?	____	____
12.	Do you get more tired than your friends during exercise?	____	____
13.	Have you ever had racing of your heart or skipped heartbeats?	____	____
14.	Have you had high blood pressure or high cholesterol?	____	____
15.	Have you ever been told you have a heart murmur?	____	____
16.	Has any family member died of heart problems or sudden death before age 50?	____	____
17.	Have you had a severe viral infection in the within the last month?	____	____
18.	Has a physician ever denied or restricted your sports activity?	____	____
19.	Do you have any current skin problems (i.e. rashes, blisters, warts, etc.)?	____	____
20.	Have you ever had a head injury or concussion?	____	____
21.	Have you ever been knocked out, lost consciousness, or lost your memory?	____	____
22.	Have you ever had a seizure?	____	____
23.	Do you have frequent or severe headaches?	____	____
24.	Have you ever had numbness or tingling in your arms, legs, hands, or feet?	____	____
25.	Have you ever had a stinger, burner, or pinched nerve?	____	____
26.	Have you ever become ill from exercising in the heat?	____	____
27.	Do you cough, wheeze, or have trouble breathing during or after exercise?	____	____
28.	Do you have asthma?	____	____
29.	Do you have seasonal allergies requiring medical treatment?	____	____
30.	Have you ever had any problems with your eyes or vision?	____	____
31.	Do you wear glasses, contacts, or protective eyewear?	____	____
32.	Have you ever had a sprain, strain, or swelling injury?	____	____
33.	Have you broken (fractured) any bones or had dislocated joints?	____	____
34.	Do you want to weigh more or less than you do now?	____	____
35.	Do you lose weight regularly to make weight for your sport?	____	____
36.	Do you feel stressed out?	____	____
37.	Are you missing any of your paired organs (i.e. eyes, lungs, kidneys, testes)?	____	____

EXPLAIN ANY "YES" ANSWERS: ______________________________

____
____
____
____
____
____
____
____

______________________________ ______________________________

SIGNATURE OF PARENT/GUARDIAN/DATE **SIGNATURE OF WITNESS/DATE**