HEALTH HISTORY

	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 currenty 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, check the affected area below:		
18. Have you had any broken or fractured bones or dislocated joints? If yes, check 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, check 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?		

	YES	NO
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?		
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?		

Student Athlete's Name:
DOB:

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

_________________________________ Date: ___/____/____
Parent/Guardian Signature

#'s	**Explain "Yes" answers here**