Medical History Questionnaire

Name__________________________Sex_______Age______Date of Birth__________________
Sport(s)___________________Phone_______________E-mail Address_____________________
In case of emergency, contact
Name_______________Relationship_________Phone(H)______________(W)______________

Explain "Yes" answers on second page

Question	Y	N
1. Has a doctor even denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
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 applies)? ☐ High Blood Pressure ☐ High Cholesterol ☐ A heart murmur ☐ A 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 died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan's syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever used an inhaler or taken asthma medicine?	☐	☐
18. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
19. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
20. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
21. Have you had a herpes skin infection?	☐	☐
22. Have you ever had a head injury or concussion?	☐	☐
23. Have you been hit in the head or been confused or lost your memory?	☐	☐
24. Have you ever had a seizure?	☐	☐
25. Do you have headaches with exercise?	☐	☐
26. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
27. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
28. When exercising in the heat do you have severe muscle cramps or become ill?	☐	☐
29. Has a doctor told you that you or someone in your family has sickle trait or sickle cell disease?	☐	☐
30. Have you had any problems with your eyes or vision?	☐	☐
31. Do you wear glasses or contact lenses?	☐	☐
32. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
33. Are you happy with your weight?	☐	☐
34. Are you trying to gain or lose weight?	☐	☐
35. Has anyone recommended you change your weight or eating habits?	☐	☐

36. Have you ever had a stress fracture? 37. Have you been told that you have or have you had an x-ray for atlantoaxial (neck)? 38. Do you regularly use a brace or assistive device? 39. Has a doctor ever told you that you have asthma or allergies? 40. Do you cough, wheeze, or have difficulty breathing during or after exercise? 41. Is there anyone in your family who has asthma?	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	42. Do you limit or carefully control what you eat? 43. Do you have any concerns that you would like to discuss with a doctor? **FEMALES ONLY** 44. Have you ever had a menstrual period? 45. How old were you when you had your first menstrual period? 46. How many periods have you had in the last year?	☐ ☐ ☐ ☐ ☐ ☐ ______ ______

Explain "Yes" answers from previous page here:____

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List all *previous injuries* and *approximate dates.* Check N/A if not applicable

N/A ☐ Shoulder/Elbow (dislocation, rotator cuff, AC separation):________________ Date:_________
N/A ☐ Arm/Wrist/Hand (fractures):____________________________________ Date:_________
N/A ☐ Neck (burners, pinched nerve):__________________________________ Date:_________
N/A ☐ Ribs/Abdomen:____ Date:_________
N/A ☐ Low back pan (herniated disc):__________________________________ Date:_________
N/A ☐ Leg (quadriceps, hamstring strain):_______________________________ Date:_________
N/A ☐ Knee (ligament, meniscus, patella):_______________________________ Date:_________
N/A ☐ Lower leg (shin splints, calf strain):_______________________________ Date:_________
N/A ☐ Ankle/Calf/Foot (sprain, Achilles):_______________________________ Date:_________
N/A ☐ Stress Fractures:____ Date:_________
N/A ☐ Concussions:____ Date:_________

If yes, have you ever been knocked out (unconscious)? Yes: ☐ No: ☐
How many times?__________________________
How long were you unconscious?____
Have you ever lost your memory? Yes: ☐ No: ☐
How many times?__________________________
Did you have problems in the days afterward (confusion, headache, concentration)?
Yes: ☐ No: ☐
How long did it take you to recover?_____________
Are you still having problems? Yes: ☐ No: ☐

Do you have any unhealed or chronic injuries? Yes: ☐ No: ☐
Please list:____

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

Signature of athlete____ Date___________

Signature of parent/guardian____Date____________