

Report of Medical History

Name _____

Sex _____ Age _____ Date of Birth _____

Address _____

Personal Physician _____

In case of emergency, contact

Name _____ Relationship _____

Home _____ Cell _____ Work _____

Explain "yes" answers below and circle the questions you do not know the answers to.

	Yes	No		Yes	No
Have you had a medical illness or injury since your last check up or physical?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently taking any prescription or nonprescription (over the counter) medications or pills or are using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	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, teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken any supplement or vitamins to help gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any allergies (for example to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear glasses, contact lenses or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a sprain, strain or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after practice?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any problems with pain or swelling in muscles, tendons, bones or joints? <i>If yes, please check the appropriate box</i>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> head <input type="checkbox"/> elbow <input type="checkbox"/> hip <input type="checkbox"/> upper arm		
			<input type="checkbox"/> neck <input type="checkbox"/> forearm <input type="checkbox"/> thigh <input type="checkbox"/> shin/calf		
			<input type="checkbox"/> back <input type="checkbox"/> wrist <input type="checkbox"/> knee <input type="checkbox"/> shoulder		
			<input type="checkbox"/> chest <input type="checkbox"/> hand <input type="checkbox"/> foot <input type="checkbox"/> finger		
			<input type="checkbox"/> shoulder		
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	Females: When was your last menstrual period? _____		
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period? _____		
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	How much time do you usually have from the start of one period to the start of another? _____		
Do you have any current skin problems (for example, rash, itching, acne, warts, fungus or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	What was the longest time between periods in the last year? _____		
Have you ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>			

Do you have frequent or severe headaches?
Have you ever had numbness or tingling in your arms, legs, hands or feet?
Have you ever had a stinger, burner or pinched nerve?

Explain “yes” answers here:

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

Signature of Athlete _____

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Reviewed by _____ **Date** _____