

Medical History

History

Date _____

Name _____ Sex _____ Age _____ Date of Birth _____

Grade _____ Sport _____

Personal physician _____ Address _____ Phone _____

Explain "yes" answers below:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Have you ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you presently taking any medication or pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any allergies (medicine, bees, or other stinging insects)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you tire more quickly than your friends during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been told that you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has anyone in your family died of heart problems or a sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any skin problems (itching, rashes, acne)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been knocked out or unconscious? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a stinger, burner, or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had heat or muscle cramps? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy or passed out in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have trouble breathing or do you cough during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear glasses or contacts or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever sprained/strained, dislocated, fractured, or broken or had repeated swelling or other injuries of any bones or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> •Head <input type="checkbox"/> •Shoulder <input type="checkbox"/> •Thigh <input type="checkbox"/> •Neck <input type="checkbox"/> •Elbow <input type="checkbox"/> •Knee <input type="checkbox"/> •Chest | | |
| <input type="checkbox"/> •Forearm <input type="checkbox"/> •Shin/calf <input type="checkbox"/> •Back <input type="checkbox"/> •Wrist <input type="checkbox"/> •Ankle <input type="checkbox"/> •Hip <input type="checkbox"/> •Hand <input type="checkbox"/> •Foot | | |
| 12. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 13. Have you had a medical problem or injury since your last evaluation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. When was your last tetanus shot? _____ | | |
| When was your last measles immunization? _____ | | |
| 15. When was your first menstrual period? _____ | | |
| When was your last menstrual period? _____ | | |
| What was the longest time between your periods last year? _____ | | |
| Are you currently or have you been under the care of a mental health professional? _____ | | |

Explain "yes" answers:

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

Date _____

Signature of athlete _____

Signature of parent/guardian _____

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