2021-2022

STUDENT-ATHLETE MEDICAL HISTORY INFORMATION FORM

Athlete's Name: _____ DOB: _____ Sport: _____

1. Please answer the following questions to the best of your knowledge. (Additional pages may be added as necessary)

		Circle		If YES, please explain below.
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	YES	NO	
2.	Do you have an ongoing medical condition? (ex. Diabetes, Asthma, ADD, ADHD, etc.)	YES	NO	
3.	Are you currently ill in any way?	YES	NO	
4.	Do you currently have any injuries that are not completely healed?	YES	NO	
5.	Have you been hospitalized overnight for any illness or injury?	YES	NO	
6.	Have you had surgery?	YES	NO	
7.	Have you passed out or become dizzy DURING or AFTER exercise?	YES	NO	
8.	Have you had pain, discomfor, or pressure in your chest during or after exercise?	YES	NO	
9.	Do you tire more quickly than your friends/teammates during exercise?	YES	NO	
10.	Have you ever had a high blood pressure reading?	YES	NO	
11.	Have you ever been told that you have a heart murmur?	YES	NO	
12.	Have you had racing of your heart or skipped heartbeats?	YES	NO	
13.	Do you suffer from shortness of breath or wheezing during exercise?	YES	NO	
14.	Do you have any rashes, pressure sores or other skin problems?	YES	NO	
15.	Have you been diagnosed with a concussion?	YES	NO	
16.	Haver you been knocked out or unconcious?	YES	NO	
17.	Have you had a seziure?	YES	NO	
18.	Have you had a stinger, burner, or pinched nerve?	YES	NO	
19.	Have you been dizzy or passed out from the heat?	YES	NO	
20.	Have you had heat illness or muscle cramps?	YES	NO	
21.	Have you had problems with your eyes or vision?	YES	NO	
22.	Do you wear glasses, contacts or protective eyewear?	YES	NO	
23.	Do you use any special equipment? (pads, braces, mouth guards, etc.)	YES	NO	
24.	Have you had any significant medical illnesses (mono, pneumonia, etc.) in the last year?	YES	NO	
25.	Have you gained or lost 10+ lb in the last year?	YES	NO	
26.	When was your most recent tetanus shot?	XXX	XXX	
27.	Any other acute or chronic injuries, illnesses, or conditions not mentioned above?	YES	NO	
28.	Do you have any medical concerns that you wish to speak to a doctor about?	YES	NO	

By signing below, I certify that all answers above are correct and true to the best of my knowledge.

Student-Athlete's Signature _____ **Date** _____ '21-'22

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2. Have **you** sprained, strained, dislocated, fractured, had repeated swelling or other injuries of ANY bones or joints?

	Circle		If YES, please explain below.
Head/Neck	YES	NO	
Back	YES	NO	
Shoulder	YES	NO	
Elbow	YES	NO	
Wrist/Hand	YES	NO	
Hip	YES	NO	
Knee	YES	NO	
Ankle/Foot	YES	NO	
Other	YES	NO	

3. Have **you** ever had or been diagnosed with any of the following?

	Circle		If YES, please explain below.
Anemia	YES	NO	
Asthma	YES	NO	
Diabetes	YES	NO	
Hearing Problems	YES	NO	
Hepatitis	YES	NO	
Hernia	YES	NO	
Migraines	YES	NO	
Mononucleosis	YES	NO	
Theumatic Fever	YES	NO	
Tuberculosis	YES	NO	
Ulcers	YES	NO	
Other	YES	NO	

4. Do **you** have allergies to any of the following?

	Circle		If YES, please list below.
Food	YES	NO	
Medication	YES	NO	
Animal (Bite/Sting)	YES	NO	
Latex	YES	NO	
Other	YES	NO	

5. List **ALL** over-the-counter and prescription medications and/or supplements you are **CURRENTLY TAKING** and/or **HAVE TAKEN** in the **PAST 18 MONTHS**. (Additional pages may be added as necessary)

	Substance	Dosage	Dates/Length of Time Taken	Purpose
1.				
2.				
3.				

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6. **FEMALES ONLY** – (Males skip to section 7)

		Circle		Please add comments below as necessary
1.	Are you happy with your current weight?	YES	NO	
2.	Are you trying to gain or lose weight?	YES	NO	
3.	Has anyone recommended that you change your weight or eating habits?	YES	NO	
4.	Do you limit or carefully control what you eat?	YES	NO	
5.	Are you a vegitarian?	YES	NO	
6.	Are you or have you experienced an irregular menstral cycle?	YES	NO	
7.	At what age was your first menstrual cycle?	N/A	N/A	
8.	Have you missed any cycles within the past 12 months?	YES	NO	If yes, what is the longest you've gone between periods?
9.	How many menstrual cycles total have you had in the past 12 months?	N/A	N/A	
10.	Are you on birth control or other hormonal medication?	YES	NO	If yes, ensure medication is listed in section 5 on previous page
11.	Are you currently pregnant?	YES	NO	
12.	Have you ever been pregnant?	YES	NO	
13.	Do you have a history of stress fractures?	YES	NO	
14.	Do you have any medical concerns that you wish to speak to a doctor about?	YES	NO	

7. Has any **blood relative** ever had or been diagnosed with the following?

	Circle		If yes, please idicate who (i.e. paternal grandmother, etc.)
Blood Disease (sickle cell, leukemia, etc.)	YES	NO	
Diabetes	YES	NO	
Epiplepsy	YES	NO	
Gout	YES	NO	
Heart Disease (including heart attack)	YES	NO	
Hemophilia	YES	NO	
High Blood Presure	YES	NO	
Marfan's Syndrom	YES	NO	
Sudden Death (before age 55)	YES	NO	

By signing below, I certify that all answers above are correct and true to the best of my knowledge.

Student-Athlete's Signature _____ **Date** _____ '21-'22