ATHLETE MEDICAL HISTORY QUESTIONNAIRE

Instructions: This form must be completed by a parent/guardian and turned in on the first day of practice.

Athlete Name (first middle last) ____

	YES	NO	
1.	[ ]	[ ]	Are you currently under a doctor's care? If so, who and why?
2.	[ ]	[ ]	Do you take any medications daily or routinely? Please list below.
3.	[ ]	[ ]	Allergic to any medications (aspirin, penicillin, etc)? Please list below.
4.	[ ]	[ ]	Allergic to any food or insect?
5.	[ ]	[ ]	Any chronic or recurrent illnesses (diabetes, asthma, ulcer, bronchitis, sickle cell anemia)?
6.	[ ]	[ ]	Any hospitalizations?
7.	[ ]	[ ]	Any illnesses requiring bed rest of on week or longer?
8.	[ ]	[ ]	Any surgery?
9.	[ ]	[ ]	Any surgery advised and not taken?
10.	[ ]	[ ]	Ever had any symptoms of heart problems?
11.	[ ]	[ ]	Chest pains?
12.	[ ]	[ ]	High blood pressure?
13.	[ ]	[ ]	Close relative under 40 to die of heart disease?
14.	[ ]	[ ]	Any dizziness, fainting, convulsions, or frequent headaches?
15.	[ ]	[ ]	Ever been "knocked out" or had a concussion?
16.	[ ]	[ ]	Wear eyeglasses of contact lenses?
17.	[ ]	[ ]	Any serious eye injuries?
18.	[ ]	[ ]	Wear any dental appliance(braces, retainer, bridge, plates)?
19.	[ ]	[ ]	Ever suffered heat exhaustion or heat stroke?
20.	[ ]	[ ]	Ever had mononucleosis? If so, month/year?
21.	[ ]	[ ]	Any history or enlarged spleen or liver?
22.	[ ]	[ ]	Any organ missing other than tonsils (appendix, eye, kidney, spleen, testicle)?
23.	[ ]	[ ]	Any history or collapsed lung or tuberculosis?
24.	[ ]	[ ]	Any knee injury?
25.	[ ]	[ ]	Any ankle injury?
26.	[ ]	[ ]	Any neck injury?
27.	[ ]	[ ]	Any other joint sprains or dislocations (shoulder, wrist, finger)?
28.	[ ]	[ ]	Any broken bones (fractures)?
29.	[ ]	[ ]	Any communicable diseases?
30.	[ ]	[ ]	Any known reason why this individual should not participate?

Describe any "YES" answers in detail below. Enter question number before each comment.
☐ Check here if using the back of sheet.

All statements answered in this record are true to the best of my knowledge. I have no abnormality, limitations, or restriction not mentioned in this record. I understand that this information is used to help determine my fitness to participate in athletics.

Student's Signature______________________________ Printed Name ___________________________Date ___________

Parent/Guardian Signature____________________________ Printed Name ___________________________Date ___________