Medical History Form

Name: _____ DOB: _____ Sport: _____

Please list all of the prescription and over-the-counter medicines and supplements (herbal & nutritional) that you are currently taking:
Please list any and all allergies you may have. (Including medicine, food, insects, pollen, etc.). If none, please write N/A.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions?		
3. Have you ever spend the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats during exercise?		
8. Has a doctor ever told you that you have any of the problems listed below? If so, circle: High cholesterol Kawasaki disease Other High blood pressure Heart murmur		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50?		
14. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
15. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONES AND JOINT QUESTIONS		
16. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
17. Have you ever had any broken bones or dislocated joints?		
18. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
19. Have you ever had a stress fracture?		
20. Have you had an x-ray for neck instability or atlantoaxial instability?		
21. Do you regularly use a brace, orthotics, or other assistive device?		
22. Do you have a bone, muscle, or joint that bothers you?		
23. Do any of your joints become painful, swollen, or red?		
24. Do you have any history of arthritis or connective tissue disease?		

FEMALES ONLY:

Age of first menstrual period. _____

When did your last menstrual period begin? _____

How many periods have you had in the last 12 months? _____

MEDICAL QUESTIONS	Yes	No
25. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
26. Have you ever used an inhaler?		
27. Is there anyone in your family with asthma?		
28. Were you born missing any organs?		
29. Have you ever had a hernia?		
30. Have you had mononucleosis (mono)?		
31. Do you have any rashes, sores, or other skin problems?		
32. Have you had herpes or MRSA?		
33. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
34. Have you ever had a head injury or concussion?		
35. Do you have a history of a seizure disorder?		
36. Do you have headaches with exercise?		
37. Have you ever had numbness, tingling, or weakness in your arms or legs after a hit?		
38. Have you ever been unable to move?		
39. Have you ever become ill while exercising in the heat?		
40. Do you get frequent muscle cramps when exercising?		
41. Do you or someone in your family have sickle cell trait or disease?		
42. Have you ever had any eye injuries?		
43. Have you had any problems with your eyes or vision?		
44. Do you wear contacts or glasses?		
45. Do you wear protective eyewear such as goggles or a face shield?		
46. Do you worry about your weight?		
47. Are you trying to or has anyone recommended that you gain or lose weight?		
48. Are you on a special diet or avoid certain types of food?		
49. Have you ever had an eating disorder?		

Explain ALL "yes" answers here:

use back if needed: