PREPARTICIPATION MEDICAL HISTORY

Name:_____ Sport :_____

Please read the following questions and check the appropriate box to the right.

GENERAL MEDICAL:	**YES**	**NO**
1. Have you ever had a prolonged medical illness?……	❑	❑
2. a. Have you ever been hospitalized overnight?……..	❑	❑
b. Have you ever had surgery?……	❑	❑
3. Are you currently taking any prescription medications (incl. birth control pills), nonprescription (over the counter) medications?…… ……	❑	❑
4. Are you currently or have you ever taken supplements or vitamins to help you gain or lose weight or to improve your performance?……	❑	❑
5. Have you had a tetanus shot within the last 10 years?……	❑	❑
6. When was you last immunization (shots) for:		
Tetanus_____ Measles_____ Hepatitis B_____ Chickenpox_____		
7. Have you ever been told that you can not or should not take part in your sport for medical reasons*?* (*This does not include bone/muscle/joint injuries*)……	❑	❑
ALLERGIES / ASTHMA:		
8. a. Do you have any drug allergies?……	❑	❑
b. Do you have any allergies to foods or stinging insects?……	❑	❑
c. Have you ever had a rash or hives develop during or immediately after exercising?……	❑	❑
9. Do you have any current skin conditions (rash, acne, warts, fungus or blisters)?….	❑	❑
10. a. Do you cough, wheeze, or have trouble breathing during or after exercise?……	❑	❑
b. Do you have asthma?……	❑	❑
c. Do you have seasonal allergies that require medical treatment?……	❑	❑
HEART:		
11. a. Have you ever passed out during or after exercise?……	❑	❑
b. Have you ever experienced *excessive* dizziness during or after exercise?……	❑	❑
c. Have you ever had chest pains during or after exercise?……	❑	❑
d. Do you tire *more quickly* than your teammates do during activity?……..	❑	❑
e. Does your heart frequently race or skip beats?……	❑	❑
f. Have you ever been told you have high blood pressure or high cholesterol?….	❑	❑
g. Have you ever been told that you have a heart murmur?……	❑	❑
h. Has a family member died of heart related illness or sudden death *before the age of 50*?……	❑	❑
i. Have you had a severe viral infection (myocarditis or mononucleosis) within the last month?……	❑	❑
j. Has a doctor ever denied or restricted your participation in sports for any heart problems?……	❑	❑

TO BE COMPLETED BY DOCTOR ONLY:

ITEM #	DESCRIPTION
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Name:_____

	YES	NO
HEAT RELATED INJURIES:		
12. a. Have you ever become ill after exercising in the heat?……	❑	❑
b. Have you ever had severe muscle cramps during activity?……..	❑	❑
c. Have you ever received IV fluids for any for a heat illness?……..	❑	❑
HEAD & NECK RELATED INJURIES:		
13. a. Have you ever had a head injury or concussion?……	❑	❑
b. Have you ever been knocked out, become unconscious, or lost your memory?……	❑	❑
c. Have you ever had a seizure?……	❑	❑
d. Do you have frequent or severe headaches?……	❑	❑
e. Have you ever had numbness or tingling in your arms, hands, legs or feet?…	❑	❑
f. Have you ever had a stinger, burner, or pinched nerve?……..	❑	❑
MISCELLANEOUS:		
14. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (knee braces, special neck roll, foot orthotics, dental appliances, or hearing aid)?……	❑	❑
15. a. Have you had any problem with your eyes or your vision……	❑	❑
b. Do you wear glasses, contacts, or protective eyewear?……	❑	❑
16. Do you wear any wear any dental appliances, dentures or partials?……	❑	❑
17. a. Do you want to weigh more or less than you do now?……..	❑	❑
b. Do you regularly gain or lose weight to meet the requirements for your sport? *(This applies to weight changes of greater than 5% of your body weight.)*……	❑	❑
18. Do you have any other medical problems that have not been mentioned above?.	❑	❑

FEMALES ONLY:

17. a. When was your first menstrual period? _____
    b. When was your most recent menstrual period?_____
    c. How many days are there from the start of one period to the start of another? _____days
    d. How many periods have you had in the past year?_____periods
    e. What was the approximate longest time between periods last year?_____days

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TO BE COMPLETED BY DOCTOR ONLY:

ITEM #	DESCRIPTION
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