ATHLETE MEDICAL HISTORY QUESTIONNAIRE

ATHLETE'S NAME (first and last) _____

Yes	No	
☐	☐	Are you currently under a doctor's care? If so, who and why?
☐	☐	Do you take any medications daily or routinely?
☐	☐	Allergic to any medications (aspirin, penicillin, etc.) food or insects?
☐	☐	Any chronic or recurrent illnesses (diabetes, asthma, ulcer, bronchitis, sickle cell, anemia)?
☐	☐	Any hospitalizations?
☐	☐	Any illnesses requiring bed rest of a week or longer?
☐	☐	Any surgery?
☐	☐	Any surgery advised and not taken?
☐	☐	Ever had any symptoms of heart problems? Chest pains?
☐	☐	High Blood Pressure?
☐	☐	Close relative under 40 to die of heart disease?
☐	☐	Any dizziness, fainting, convulsions, or frequent headaches?
☐	☐	Ever been knocked out or had a concussion?
☐	☐	Wear eyeglasses or contact lenses? Any serious eye injuries?
☐	☐	Wear any dental appliances (braces, retainer, bridge, plates)?
☐	☐	Ever suffered heat exhaustion or heat stroke?
☐	☐	Ever had mononucleosis? If so, month/year?
☐	☐	Any history of enlarged spleen or liver?
☐	☐	Any organ missing other than tonsils (appendix, eye, kidney, spleen, testicle)?
☐	☐	Any history of collapsed lung or tuberculosis?
☐	☐	Any knee, ankle or neck injuries?
☐	☐	Any other joint sprains or dislocations (shoulder, wrist, finger)?
☐	☐	Any broken bones (fractures)?
☐	☐	Any communicable diseases?
☐	☐	Any known reason why this individual should not participate?
☐	☐	Has the athlete or any family member had a problem with anesthesia?
☐	☐	Females Only: Do you take any medication to control menstrual discomfort?

Describe any "YES" answers below in detail. Enter question number before each comment. _____

_____

_____

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

Athlete's Signature_____Date_____

Parent/Guardian Signature_____Date_____