

Medical History

1. Do you have any chronic or ongoing medical conditions?
 If yes, explain: _____ Yes No

2. Have you ever been hospitalized and/or had surgery for any reason?
 If yes, explain: _____ Yes No

3. Do you have any allergies (medications, insects, foods, etc.)?
 If yes, explain: _____ Yes No

4. Are you currently taking any medications or supplements (include over-the-counter)?
 If yes, explain: _____ Yes No

5. Have you had a medical problem or injury since your last physical exam?
 If yes, explain: _____ Yes No

6. Have you ever passed out or nearly passed out during or after exercise?
 Have you ever had chest pain, tightness, or pressure during or after exercise?
 Have you ever been dizzy or light headed during or after exercise?
 Do you get more tired or short of breath than others during exercise?
 Does your heart ever race or skip beats (irregular beats) during exercise?
 Has a doctor ever ordered a test for your heart (e.g. ECG/EKG, echocardiogram)?
 Have you ever been told you have any of the following (check all that apply):
 High blood pressure Heart murmur High cholesterol
 A heart infection Kawasaki disease Other: _____
 Explain ALL yes answers & checked items: _____

7. Has anyone in your family died suddenly or of heart problems before age 50?
 Do anyone in your family have a heart problem, pacemaker, or implanted defibrillator?
 Has anyone in your family had unexplained fainting, seizures, or near drowning?
 Does anyone in your family have any of the following cardiovascular conditions:
 Hypertrophic cardiomyopathy Marfan syndrome Brugada syndrome
 Arrhythmogenic right ventricular cardiomyopathy Long QT syndrome
 Catecholaminergic polymorphic ventricular tachycardia Short QT syndrome
 Explain ALL yes answers & checked items: _____

8. Have you ever had a concussion, head injury, or recurrent headaches?
 If yes, explain: _____ Yes No

Have you ever been knocked out or unconscious?
 If yes, explain: _____ Yes No

Do you have headaches with exercise?
 If yes, explain: _____ Yes No

Have you ever had any of the following after a hit, blow to the head, or falling:
 Confusion Prolonged headache Inability to move your arms or legs
 Memory problems Numbness, tingling, or weakness in your arms or legs
 Explain ALL checked items (include dates): _____

Have you ever had a stinger, burner, or pinched nerve?
 If yes, explain: _____ Yes No

Have you ever had seizures, convulsions, or a history of epilepsy?
 If yes, explain: _____ Yes No

9. Have you ever become ill, dizzy, or passed out while exercising in the heat?
 If yes, explain: _____ Yes No

Do you get frequent muscle or heat cramps when exercising?
 If yes, explain: _____ Yes No

Do you or someone in your family have sickle cell trait or disease?
 If yes, explain: _____ Yes No

10. Do you or someone in your family have asthma or another obstructive lung disorder?
 If yes, explain: _____ Yes No

Do you cough, wheeze, or have difficulty breathing during or after exercise?
 If yes, explain: _____ Yes No

Have you ever used an inhaler or taken asthma medication?
 If yes, explain: _____ Yes No

11. Do you currently have, or have you EVER HAD any of the following:
 Hernia Mononucleosis Diabetes Kidney disease Scoliosis Absent spleen
 Explain ALL checked items (include dates): _____

12. Are you missing one of a set of paired organs (kidneys, eyes, ovaries, testes, etc.)?
 If yes, explain: _____ Yes No

13. Have you ever sprained, strained, dislocated, fractured, broken, experienced repeated swelling in, had a stress fracture in, or otherwise injured any bones or joints? (check all that apply)
 Head Neck Chest/ribs Back Shoulder Forearm Elbow Wrist
 Hip Thigh Calf/fin Knee Ankle Foot/toes Hand/fingers
 Explain ALL checked answers (include dates): _____

14. Have you ever had a condition/injury that required x-rays, MRI, CT scan, or therapy?
 If yes, explain: _____ Yes No

15. Do you use any special equipment (braces, pads, mouthguards, neck rolls, etc.)?
 If yes, explain: _____ Yes No

Do you wear glasses, corrective lenses, or protective eyewear?
 Explain ALL yes answers: _____ Yes No

16. Have you ever had any skin problems (rashes, itching, MRSA, herpes, acne)?
 If yes, explain: _____ Yes No

17. Have you ever had an eating disorder or restricted food to lose weight?
 Do you want to weigh MORE or LESS than you do now?
 Do you feel stressed?
 Explain ALL yes answers: _____ Yes No

20. FEMALES ONLY Age at 1st menstrual period? _____ Date of most recent?
 Number of periods in the last 12 months? _____ Longest time between periods? _____

21. Has a doctor ever denied or restricted your participation in sports for any reason?
 If yes, explain: _____ Yes No

**I hereby state that, to the best of my knowledge, the answers to the above questions are complete and correct.
 Signature of Athlete: _____ Date: _____
 Signature of Parent/Guardian: _____ Date: _____