



2004-2005 Medical History Form



Name _____ DOB _____ Sport _____

School Address _____ Local Phone _____

Parent's Name _____ Home Phone _____

Home Address _____

Please answer all of the following questions. Explain any "yes" answers in the spaces provided.

- 1. Do you have any known allergies? (including latex)
2. Are you currently on medication? (include birth control)
3. Have you ever been hospitalized?
4. Have you ever had surgery?
5. Have you ever fainted/felt dizzy during exercise?
6. Have you ever had chest pain during exercise?
7. Have you ever had heart trouble?
8. Have you ever had high blood pressure?
9. Have you ever had a heat related illness? (cramps, dizziness, fainting?)
10. Do you have any other medical problems? (including, but not limited to, mono, hepatitis, AIDS, asthma, diabetes, loss or impaired function of any organ)
11. Has anyone in your family died suddenly before age 50 of heart problems?
12. Do you have any menstrual irregularities/problems?
13. Have you ever injured (sprained, dislocated, fractured) any of the following:

Neck____ Hip____ Foot____ Toes____ Shoulder____ Thigh____ Arm____ Head____
Chest____ Knee____ Elbow____ Ankle____ Back____ Lower leg____ Wrist____ Hand____
Fingers____

If yes, please indicate injured side of body and when injury occurred on the lines provided below:

I, _____, certify that the above information is accurate to the best of my knowledge.

Athlete/Parent/Guardian Signature _____

Date _____