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.

	Yes	No	Explanation
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 _____