

**\*SPORTS HISTORY FORM\***

NAME \_\_\_\_\_ DOB \_\_\_\_\_ CHART # \_\_\_\_\_

**Explain "Yes" answers below. Circle any questions you do not know the answers to.**

- 1. Has a doctor ever denied or restricted your participation in sports for any reason?-----Yes No
- 2. Do you have an ongoing medical condition (like diabetes or asthma)?-----Yes No
- 3. Are you currently taking any prescription or over-the-counter medicines or pills? -----Yes No
- 4. Do you have allergies to medicines, pollens, foods, or stinging insects?-----Yes No
- 5. Have you ever passed out or nearly passed out **DURING or AFTER** exercise? -----Yes No
- 6. Have you ever had discomfort, pain, or pressure in your chest during exercise?-----Yes No
- 7. Has a doctor ever told you that you or anyone in your family have (*check all that apply*):  
     \_\_\_\_\_ high blood pressure      \_\_\_\_\_ a heart murmur      \_\_\_\_\_ a heart problem
- 8. Has a doctor ever ordered a test for your heart (like an ECG, echocardiogram)? ----- Yes No
- 9. Has any family member or relative died of heart problems or sudden death before age 50? ----- Yes No
- 10. Does anyone in your family have Marfan Syndrome? ----- Yes No
- 11. Have you ever had surgery? ----- Yes No
- 12. **Have you ever had bone, joint, muscle or ligament injury that caused you to miss a practice or game? Any fractures, stress fractures or dislocated joints?**----- Yes No
- 13. Have you been told that you have or have you been x-rayed for atlantoaxial (neck) instability? ----- Yes No
- 14. Do you regularly use a brace or assistive device? ----- Yes No
- 15. Has a doctor ever told you that you or anyone in your family has asthma? ----- Yes No
- 16. Do you cough, wheeze, or have difficulty breathing during or after exercise? ----- Yes No
- 17. Have you ever used an inhaler or taken an asthma medicine? ----- Yes No
- 18. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? ----- Yes No
- 19. Have you had infectious mononucleosis (mono) within the last month? ----- Yes No
- 20. Do you have any rashes, pressure sores, or other skin problems? ----- Yes No
- 21. Have you ever had a head injury, concussion; been confused or lost your memory? ----- Yes No
- 22. Have you ever had a seizure? ----- Yes No
- 23. Do you have headaches with exercise?----- Yes No
- 24. Have you ever had numbness, tingling, or weakness; or been unable to move in your arms or legs after being hit or falling?----- Yes No
- 25. When exercising in the heat, do you have severe muscle cramps or become ill? ----- Yes No
- 26. Has a doctor told you that you or someone in your family has sickle cell trait or disease? ----- Yes No

**FEMALES ONLY**

27. How many periods have you had in the last 12 months? \_\_\_\_\_

**Explain "Yes" answers here:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>I hereby state that to the best of my knowledge my answers to the above questions are complete and correct:</b>	
Signature of Athlete _____	Date _____
Signature of Parent/Guardian _____	Date _____
Physician Signature: _____	Date _____