

Medical History

This form must be completed by a parent or guardian prior to the physical examination and should be taken with the physical exam form for review by the physician during the examination.

Yes No

1. Has your child ever had any of the following?

____ ____ Broken Bones: _____ Weak Joints- ankles, knees: _____
____ ____ Spinal Injury: _____ Seizures or Epilepsy: _____
____ ____ Concussion: _____ Operation: _____
____ ____ Referred pain, such as a "burner" or a "stinger": _____
____ ____ Injury or illness that excluded athletic participation previously: _____

2. Cardiovascular History

____ ____ Has your child ever fainted or passes out? _____
____ ____ Has your child ever had chest pain or discomfort with exercise? Has your child ever had to stop running or exercising because of chest pain or shortness of breath? _____
____ ____ Has your child ever has excessive, unexpected, or unexplained shortness of breath associated with exercise? _____
____ ____ Does your child ever cough, wheeze, or have trouble breathing during or after activity? _____
____ ____ Has your child ever become ill from exercising in the heat? _____
____ ____ Has your child ever had excessive, unexpected, or unexplained fatigue associated with exercise? _____

____ ____ Has your child ever been found to have a heart murmur? _____
____ ____ Has your child ever had high blood pressure (hypertension)? _____
____ ____ Has any family member died prematurely (before age 50 –sudden/otherwise)? _____
____ ____ Is there any family history of significant disability due to cardiovascular disease in a close relative less than 50 years of age? _____
____ ____ Does your child have any specific knowledge of the occurrence of specific cardiovascular conditions such as hypertrophic cardiomyopathy, dilated cardiopathy, long QT syndrome, Marfan syndrome, or clinically important arrhythmias? _____

3. General Information

____ ____ Has your child ever been knocked out (concussion)? _____
____ ____ Has your child ever been hospitalized? _____
____ ____ Has your child ever had significant allergies to bee stings, foods, medicine, etc? _____

____ ____ Does your child have asthma? (if yes how is it treated?) _____
____ ____ Does your child take any medication regularly (prescription/nonprescription)? _____

____ ____ Has your child had any illness lasting a week or more such as mononucleosis, etc? _____
____ ____ Has your child had any blood disorders, including sickle cell train, anemia, etc? _____
____ ____ Is your child a diabetic? (if yes how are your being treated?) _____
____ ____ Does your child wear contact lenses, eyeglasses, or dental appliances? _____
____ ____ Do you have missing or non-functioning organs, i.e. tentes, eye, kidney, etc? _____
____ ____ Are you aware of any skin conditions or changes in the appearance of skin on your child? _____

____ ____ Has you child experiences a significant change in weight (gain or loss or 10 lbs or more) in the last year? _____
____ ____ Does your child have any other significant health problems? _____

Record the dates for your child's most recent immunizations for:

Tetanus _____ Measles _____
Hepatitis _____ Chickenpox _____

Females Only When was your child's first menstrual period? _____
When was your child's most recent menstrual period? _____
How much time is there between the start of one period to the start of another? _____
What was the longest time between periods in the last year? _____

Parent/Guardian Signature: _____ **Date:** _____

Student Athlete Signature: _____ **Date:** _____

pdfMachine

A pdf writer that produces quality PDF files with ease!

Produce quality PDF files in seconds and preserve the integrity of your original documents. Compatible across nearly all Windows platforms, if you can print from a windows application you can use pdfMachine.

Get yours now!