History Form for Sport Physical

Name_____ Sex_____ Age_____ Grade _____ Birth date _____
School_____ Sports _____
Address _____
Primary Physician _____ Emergency Contact _____

Check yes or no, please explain "yes" answers below. Circle questions you don't know the answer to.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up?			18. Do you cough, wheeze or have trouble breathing during or after activity?		
2. Have you ever been hospitalized? Have you ever had surgery?			19. Do you have asthma?		
3. Are you currently using an inhaler or taking any prescription or over-the-counter medications? If so, please list: _____ _____ _____ _____			20. Do you use any protective or corrective equipment that aren't usually used for your sports position (such as a knee brace, foot orthotics, hearing aid)? _____ 21. Have you had any problems with your eyes or vision? Do you wear contacts or glasses?		
4. Do you have allergies (food, drug, pollen, or insect stings)?			22. Have you ever had a sprain, strain, or swelling after an injury?		
5. Have you ever passed out or been dizzy during or after exercise?			23. Have you ever had any broken or fractured bones or dislocated joints?		
6. Have you ever had a racing heart or skipped heartbeats?			*Mark the appropriate boxes for past injury sites and explain below:* __Head __Elbow __Hip __Neck __Forearm __Thigh __Back __Wrist __Knee __Shoulder __Hand __Calf __Upper arm __Finger __Ankle __Foot		
7. Have you ever had high blood pressure or high cholesterol?					
8. Have you ever been told you have a heart murmur?					
9. Has any family member died of heart problems or of sudden death before the age of 50?					
10. Have you had any severe viral infections in the last month?			24. Do you feel stressed out?		
11. Has a physician ever denied or restricted your participation in sports?			FEMALES ONLY: 26.When was your first menstrual period? _____		
12. Do you have any current skin problems (such as itching, rash, warts or blisters)?			27. When was your most recent menstrual period? _____		
13. Have you ever had a head injury or concussion?			28. How many periods have you had in the past year? _____		
14. Have you ever had a seizure?			29. Are your periods regular?		
15. Do you have frequent or severe headaches?			Explain "Yes" Answers here: _____		
16. Have you ever had numbness or tingling in your hands, arms, feet or legs?					
17. Have you ever become ill while exercising in the heat?					

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct

_____ _____ ____/____/____
Signature of athlete Signature of parent/guardian Date