

SECTION 6: HEALTH HISTORY

Explain "Yes" answers at the bottom of this form. Circle questions you don't know the answers to.

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| <p>1. Has a doctor ever denied or restricted your participation in sport(s) for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Do you have an ongoing medical condition (like asthma or diabetes)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you have allergies to medicines, pollens, foods, or stinging insects? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you ever passed out or nearly passed out DURING exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you ever passed out or nearly passed out AFTER exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever had discomfort, pain, or pressure in your chest during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Does your heart race or skip beats during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Has a doctor ever told you that you have (check all that apply):</p> <p><input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection</p> <p>10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Has anyone in your family died for no apparent reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Does anyone in your family have a heart problem? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Does anyone in your family have Marfan Syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Have you ever spent the night in a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <div style="border: 1px solid black; padding: 5px;"> <p>17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, which caused you to miss a Practice or Contest? If yes, circle affected area below:</p> <p>18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:</p> <p>19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:</p> </div> <table border="0" style="width: 100%; font-size: small;"> <tr> <td>Head</td> <td>Neck</td> <td>Shoulder</td> <td>Upper arm</td> <td>Elbow</td> <td>Forearm</td> <td>Hand/ Fingers</td> <td>Chest</td> </tr> <tr> <td>Upper back</td> <td>Lower back</td> <td>Hip</td> <td>Thigh</td> <td>Knee</td> <td>Calf/shin</td> <td>Hand/ Fingers Ankle</td> <td>Foot/ Toes</td> </tr> </table> <p>20. Have you ever had a stress fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Do you regularly use a brace or assistive device? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | Head | Neck | Shoulder | Upper arm | Elbow | Forearm | Hand/ Fingers | Chest | Upper back | Lower back | Hip | Thigh | Knee | Calf/shin | Hand/ Fingers Ankle | Foot/ Toes | <p>23. Has a doctor ever told you that you have asthma or allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Is there anyone in your family who has asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. Have you ever used an inhaler or taken asthma medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28. Have you had infectious mononucleosis (mono) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>29. Do you have any rashes, pressure sores, or other skin problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>30. Have you ever had a herpes skin infection? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <div style="border: 1px solid black; padding: 5px;"> <p>CONCUSSION OR TRAUMATIC BRAIN INJURY</p> <p>31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>32. Have you been hit in the head and been confused or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>33. Do you experience dizziness and/or headaches with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </div> <p>34. Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>36. Have you ever been unable to move your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>37. When exercising in the heat, do you have severe muscle cramps or become ill? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>39. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>40. Do you wear glasses or contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>41. Do you wear protective eyewear, such as goggles or a face shield? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>42. Are you unhappy with your weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>43. Are you trying to gain or lose weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>44. Has anyone recommended you change your weight or eating habits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>45. Do you limit or carefully control what you eat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>46. Do you have any concerns that you would like to discuss with a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>FEMALES ONLY</p> <p>47. Have you ever had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>48. How old were you when you had your first menstrual period? _____</p> <p>49. How many periods have you had in the last 12 months? _____</p> <p>50. Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| Head | Neck | Shoulder | Upper arm | Elbow | Forearm | Hand/ Fingers | Chest | | | | | | | | | | |
| Upper back | Lower back | Hip | Thigh | Knee | Calf/shin | Hand/ Fingers Ankle | Foot/ Toes | | | | | | | | | | |

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| #s | Explain "Yes" answers here: |
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| | |

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature _____ Date ____/____/____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent's/Guardian's Signature _____ Date ____/____/____