



ATHLETIC PRE-PARTICIPATION HEALTH HISTORY
(Student to complete this page)

Name: _____

Sport: _____

Student ID: _____

Birth date: _____

Address: _____

City: _____

State: _____

Zip: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Immunization History: Proof of immunizations is required for athletic clearance. Please bring your immunization records with you to your screening.

MMR #1 (date) ____/____/____

MMR #2 (date) ____/____/____

Tdap/Td (date) ____/____/____

Explain any "Yes" answers in the space provided. Circle any questions to which you do not know the answer.	Yes	No	If Yes please Explain
1. Has a doctor ever denied or restricted your participation in sports for any reason?			
2. Do you have an ongoing medical condition (like diabetes or asthma)?			
3. Are you currently taking any prescription or nonprescription medicines or pills?			
4. Do you have allergies to medicines, pollens, foods or stinging insects?			
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			
6. Have you ever had discomfort, pain, or pressure in your chest during exercise?			
7. Does your heart race or skip beats during exercise?			
8. Has a doctor ever told you that you have (check) <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Heart infection			
9. Has a doctor ever ordered a test for your heart? (example: EKG, echocardiogram)			
10. Has anyone in your family died for no apparent reason?			
11. Does anyone in your family have a heart problem?			
12. Has any family member / relative died of heart problems or of sudden death before age 50?			
13. Does anyone in your family have Marfan syndrome?			
14. Have you ever spent the night in a hospital?			
15. Have you ever had surgery?			

If YES to any of the following questions, circle the affected area below.				Yes	No	If Yes please Explain	
16. Have you ever had an injury, like a sprain, muscle or ligament tear, that caused you to miss a practice or game?							
17. Have you had any broken or fractured bones or dislocated joints?							
18. Have you had an injury that required x-rays MRI, CT, surgery, injections, rehab, physical therapy, a brace, a cast, or crutches?							
Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/Shin	Ankle	Foot/Toes
Explain any "Yes" answers in the space provided. Circle any questions to which you do not know the answer.				Yes	No	If Yes please Explain	
19. Have you ever had a stress fracture?							
20. Do you regularly use a brace or assistive device?							
21. Has a doctor ever told you that you have asthma or allergies?							
22. Do you cough, wheeze, or have difficulty breathing during or after exercise?							
23. Have you ever used an inhaler or taken asthma medicine?							
24. Were you born without or are you missing a kidney, an eye, a testicle or another organ?							
25. Have you had mono within the last month?							
26. Do you have any rashes, pressure sores, or other skin problems							
27. Have you ever had a head injury or concussion?							
28. Have you been hit in the head and been confused or lost your memory?							
29. Have you ever had a seizure?							
30. Do you have headaches with exercise?							
31. Have you had numbness, tingling, or weakness in your arms or legs after being hit or falling?							
32. When exercising in the heat, do you have severe muscle cramps or become ill?							
33. Has a doctor told you that you or a family member has sickle cell trait or sickle cell disease?							
34. Have you had any problems with your eyes or vision?							
35. Do you wear glasses, contact lenses, or protective eyewear, such as goggles or a face shield?							
36. Are you happy with your weight?							
37. Are you trying to gain or lose weight?							
38. Has anyone recommended you change your weight or eating habits?							
39. Do you limit or carefully control what you eat?							
40. Do you have any concerns that you would like to discuss with a healthcare provider							