Health Questionnaire (Pre-participation)

Name_____ Sex_____ Age_____ Date of birth_____

Grade_____ School_____ Sport_____

Explain "Yes" answers below. Circle "Yes" or "No" to each question. Circle questions you don't know the answer to.

	Yes	No
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 non- prescription (over the counter) medications or pills?	☐	☐
4. Do you have any allergies? (i.e., medicines, pollens, latex, foods, or stinging insects?	☐	☐
5. Do you have an Epi-Pen?	☐	☐
6. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
7. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
8. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
9. Does your heart race or skip beats during exercise?	☐	☐
10. Has a doctor ever told you that you have (check all that apply) _____high blood pressure _____a heart murmur _____high cholesterol _____a heart infection	☐	☐
11. Has a doctor ever ordered a test for your heart (for example, ECG, echocardiogram)?	☐	☐
12. Has anyone in your family died for no apparent reason?	☐	☐
13. Does anyone in your family have a heart problem?	☐	☐
14. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
15. Have you ever had surgery?	☐	☐
16. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below:	☐	☐
17. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
18. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, cast, or crutches? If yes, circle affected area below:	☐	☐

	Yes	No
19. Have you ever had a stress fracture?	☐	☐
20. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
21. Do you regularly use a brace or assistive device?	☐	☐
22. Has a doctor ever told you that you have asthma or allergies?	☐	☐
23. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
24. Is there anyone in your family who has asthma?	☐	☐
25. Have you ever used an inhaler or taken asthma medicine?	☐	☐
26. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
27. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
28. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
29. Have you had a herpes or staph skin infection?	☐	☐
30. Have you ever had a head injury or concussion?	☐	☐
31. Have you been hit in the head and been confused or lost your memory?	☐	☐
32. Have you ever had a seizure?	☐	☐
33. Do you have headaches with exercise?	☐	☐
34. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
35. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
36. Have you had any problems with your eyes or vision?	☐	☐
37. Do you wear glasses or contact lenses?	☐	☐
38. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
39. Are you trying to gain or lose weight?	☐	☐
40. Has anyone recommended you change your weight or eating habits?	☐	☐
41. Do you limit or carefully control what you eat?	☐	☐

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest	Explain ALL "Yes" answers here: _____
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/ Toes	

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: _____

****It is the responsibility, as a parent / guardian, to inform the school's office staff and nurse, in writing, if any personal / medical information regarding your child has changed. This form will be good for the 3 sport seasons in 1 calendar school year. ****