SECTION 5: HEALTH HISTORY

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

1. Has a doctor ever denied or restricted your participation in sport(s) for any reason? Yes No
2. Do you have an ongoing medical condition (like asthma or diabetes)? Yes No
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? Yes No
4. Do you have allergies to medicines, pollen, foods, or stinging insects? Yes No
5. Have you ever passed out or nearly passed out DURING exercise? Yes No
6. Have you ever passed out or nearly passed out AFTER exercise? Yes No
7. Have you ever had discomfort, pain, or pressure in your chest during exercise? Yes No
8. Does your heart race or skip beats during exercise? Yes No
9. Has a doctor ever told you that you have (check all that apply):
   - High blood pressure
   - Heart murmur
   - High cholesterol
   - Heart infection
   - Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram) Yes No
   - Has anyone in your family died for no apparent reason? Yes No
10. Does anyone in your family have a heart problem? Yes No
11. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50? Yes No
12. Does anyone in your family have Marfan syndrome? Yes No
13. Have you ever spent the night in a hospital? Yes No
14. Have you ever had surgery? Yes No
15. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendinitis, which caused you to miss a practice or contest? Yes No
16. Have you had any broken or fractured bones or dislocated joints? Yes No
17. 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? Yes No
18. Have you ever had a stress fracture? Yes No
19. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? Yes No
20. Do you regularly use a brace or assistive device? Yes No
21. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? Yes No
22. Have you been in the head and been confused or lost your memory? Yes No
23. Do you experience dizziness and/or headaches with exercise? Yes No
24. Have you ever had a seizure? Yes No
25. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? Yes No
26. Have you ever been unable to move your arms or legs after being hit or falling? Yes No
27. When exercising in the heat, do you have severe muscle cramps or become ill? Yes No
28. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? Yes No
29. Have you had any problems with your eyes or vision? Yes No
30. Do you wear glasses or contact lenses? Yes No
31. Do you wear protective eyewear, such as goggles or a face shield? Yes No
32. Are you unhappy with your weight? Yes No
33. Are you trying to gain or lose weight? Yes No
34. Has anyone recommended you change your weight or eating habits? Yes No
35. Do you limit or carefully control what you eat? Yes No
36. Do you have any concerns that you would like to discuss with a doctor? Yes No
37. FEMALES ONLY: Have you ever had a menstrual period? Yes No
38. How old were you when you had your first menstrual period? Yes No
39. How many periods have you had in the last 12 months? Yes No
40. Are you pregnant? Yes No

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 __/__/____