

# Student Athletic or Activity Health History

Complete this form (with parent if < 18) and bring to your appointment. This form will be placed in the physician's file for the athlete and will <i>NOT</i> be shared with schools or sports organizations.	
Name:	Date of Birth:
School:	Phone Number:
Sport(s) or Activities:	
Sex assigned at birth (F, M, or intersex):	Gender (F, M, or other):

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

## FEMALES ONLY

Have you ever had a menstrual period?	Yes	No
Age when you had your first menstrual period?		
How many periods have you had in the last 12 months?		
Write number here:		

HEALTH HISTORY		Yes	No	HEALTH HISTORY		Yes	No
1	Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	25	Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
2	Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	26	Have you ever been diagnosed with asthma or other allergic disorders?	<input type="checkbox"/>	<input type="checkbox"/>
3	Are you currently taking any prescription or non-prescription (over the counter) medicines, supplements, or pills?	<input type="checkbox"/>	<input type="checkbox"/>	27	Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
4	Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	28	Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
5	Do you have prescriptions for use of epinephrine, adrenalin, inhaler, or other allergy medications?	<input type="checkbox"/>	<input type="checkbox"/>	29	Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6	Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
7	Have you ever passed out or nearly passed out at any other time?	<input type="checkbox"/>	<input type="checkbox"/>	31	Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
8	Have you ever had to stop running after 1/4 to 1/2 mile for chest pain or shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	32	Have you ever had herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
9	Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	33	Have you ever been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
10	Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	34	Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
11	Has a doctor said you have (check all that apply): <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection	<input type="checkbox"/>	<input type="checkbox"/>	35	Date of last head injury or concussion: _____		
12	Has any family member or relative died of heart problems or sudden death before age 35? (This does not include accidental death.)	<input type="checkbox"/>	<input type="checkbox"/>	36	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
13	Has anyone in your family died suddenly for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	37	Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
14	Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	38	Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
15	Has a doctor ever ordered a test for your heart?	<input type="checkbox"/>	<input type="checkbox"/>	39	Have you ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
16	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	<input type="checkbox"/>	<input type="checkbox"/>	40	Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
17	Does anyone in your family have a genetic heart problem, such as Marfan syndrome, hypertrophic cardiomyopathy (HCM), arrhythmogenic right ventricular cardiomyopathy (ARVC), long or short QT syndrome (LQTS or SQTs), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	<input type="checkbox"/>	<input type="checkbox"/>	41	When exercising in heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
18	Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	42	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
19	Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	43	Have you had any other blood disorders or anemia?	<input type="checkbox"/>	<input type="checkbox"/>
20	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?	<input type="checkbox"/>	<input type="checkbox"/>	44	Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
21	Have you had any broken or fractured bones or dislocated joints?	<input type="checkbox"/>	<input type="checkbox"/>	45	Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
22	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?	<input type="checkbox"/>	<input type="checkbox"/>	46	Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
23	Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	47	Are you unhappy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
24	Have you ever had an x-ray of your neck for atlanto-axial instability? OR Have you ever been told that you have that disorder or any neck/spine problem?	<input type="checkbox"/>	<input type="checkbox"/>	48	Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
				49	Are you on a special diet or do you avoid certain types of foods or food groups?	<input type="checkbox"/>	<input type="checkbox"/>
				50	Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
				51	Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>

**Explain "Yes" answers here:**

I hereby state that, to the best of my knowledge, the answers to the questions on this form are complete and correct.

Parent/Guardian signature: \_\_\_\_\_

Date: \_\_\_\_\_

Athlete Signature: \_\_\_\_\_

Date: \_\_\_\_\_