



Medical History Questionnaire

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To be completed by athlete or parent prior to examination

Name \_\_\_\_\_ Sport \_\_\_\_\_
Last First Middle

Address \_\_\_\_\_ Phone \_\_\_\_\_

Social Security Number \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Class \_\_\_\_\_

Parent's Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

Family Doctor \_\_\_\_\_ City/State \_\_\_\_\_ Phone \_\_\_\_\_

Past Medical History

Yes No If yes, explain (what, where, when)

- 1. Have you been diagnosed with asthma?
2. Have you been prescribed by a physician to use asthma medication?
3. Do you have a current consent form to self-administer the asthma medication on file with your school?
4. Allergic to medicine, foods, bee stings?
5. Wears glasses, contact lenses?
6. History of braces, chipped teeth, bridges?
7. Has ongoing medical problem?
8. Had serious or significant illness in past?
9. Any past surgical operations, accidents, non-sports or related injuries?
10. Any known deformities (such as curvature of back, heart, kidney, blindness, etc)?
11. Any serious family illness (such as diabetes, bleeding disorders, etc.)?
12. Family history of cancer?
13. Heart
Have you ever passed out during or after exercise?
Do you get tired more quickly than your friends do during exercise?
Have you ever had racing of your hear or skipped heartbeats?
Have you had high blood pressure or high cholesterol?
Have you ever been told you have a heart murmur?
Has any family member or relative died of heart problems or of sudden death before age 50?
Have you had a severe viral infection (ex; myocarditis, mononucleosis) within the last month?
Has a physician ever denied or restricted your participation in sports for any heart problems?
Has anyone in your family had a heart attack before the age of 50?
14. Head and Nerve
Have you ever had a head injury or concussion?
Have you ever been knocked out, become unconscious, or lost your memory?
Have you ever had a seizure?
Do you have frequent or severe headaches?
Have you ever had numbness or tingling in your arms, hands, legs or feet?
Have you ever had a stinger, burner, or pinched nerve?

Medical History Questionnaire

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Student's Name \_\_\_\_\_ School Name \_\_\_\_\_

Consent Form to Self-Administer Asthma Medication

Parent Consent

I, \_\_\_\_\_, do hereby give my son/daughter, \_\_\_\_\_, permission to self-administer his/her asthma medication as prescribed by his/her physician during athletic competition.

Parent's Signature (if student-athlete is under 18 years of age) \_\_\_\_\_

Date \_\_\_\_\_

Physician Consent

As a patient under my care, \_\_\_\_\_, is prescribed to self-administer the following asthma medication:

Medication \_\_\_\_\_ Purpose \_\_\_\_\_

Dosage \_\_\_\_\_ Time/ Special Circumstances \_\_\_\_\_

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_

Physical Examination

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Pulse: Resting \_\_\_\_\_ 15 hops \_\_\_\_\_ after 2 minutes resting \_\_\_\_\_

Visual Acuity: Eyes (R) 20/ \_\_\_\_\_ w/o glasses \_\_\_\_\_ (L) 20/ \_\_\_\_\_ w/glasses \_\_\_\_\_

Other Testing

|                          | Normal | Abnormal Findings |                     | Normal | Abnormal Findings |
|--------------------------|--------|-------------------|---------------------|--------|-------------------|
| 1. General               | _____  | _____             | 13. Marfan Screen   | _____  | _____             |
| 2. Skin                  | _____  | _____             | 14. Musculoskeletal |        |                   |
| 3. HEENT                 | _____  | _____             | Neck                | _____  | _____             |
| 4. Teeth (Dental Exam)   | _____  | _____             | Shoulder/Arm        | _____  | _____             |
| 5. Neck                  | _____  | _____             | Elbow/Forearm       | _____  | _____             |
| 6. Lungs                 | _____  | _____             | Wrist/Hand          | _____  | _____             |
| 7. Heart (sit and stand) | _____  | _____             | Back                | _____  | _____             |
| 8. Abdomen               | _____  | _____             | Hip/Thigh           | _____  | _____             |
| 9. Genitalia             | _____  | _____             | Knee                | _____  | _____             |
| 10. Peripheral Pulses    | _____  | _____             | Shin/Calf           | _____  | _____             |
| 11. Neurologic           | _____  | _____             | Ankle/Leg           | _____  | _____             |
| 12. Mental Status        | _____  | _____             | Foot                | _____  | _____             |

On the basis of the examination on this day, I approve this student's participation in intercollegiate sports for one year.

Yes \_\_\_\_\_ No \_\_\_\_\_ Limited \_\_\_\_\_

Additional Comments/Recommendations for Handling Above Abnormalities: \_\_\_\_\_

Physician's Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date of Examination \_\_\_\_\_