



Pre-Season Health History Questionnaire

Name: _____ Sport(s) _____

Address: _____ Phone: _____

Date of Birth ____/____/____ Sex: M F Year in School 1 2 3

Record Illnesses – check those which have occurred at any time; start with those suffered in last 5 years.

- | | | |
|---------------------|------------------|-----------------------|
| _____ Asthma | _____ Hernia | _____ Pneumonia |
| _____ Epilepsy | _____ Diabetes | _____ Appendicitis |
| _____ Tuberculosis | _____ Measles | _____ Mumps |
| _____ Mononucleosis | _____ Chickenpox | _____ Rheumatic Fever |

Indicate which of the following apply to you. **Explain any YES answers below**

Y	N	Aching Eyes	Y	N	Frequent Urination
Y	N	Blurred Vision	Y	N	Painful Urination
Y	N	Hearing Loss	Y	N	Kidney Stone or Blood in Urine
Y	N	Recurring Headaches	Y	N	Missing Kidney or Other Paired Organs
Y	N	Blackouts	Y	N	Abdominal Pains
Y	N	Fainting Spells	Y	N	Stomach, Liver, Intestinal Problems
Y	N	Painful Joints	Y	N	Loss of Memory or Amnesia
Y	N	Bone, Joint or Other Deformity	Y	N	Loss of a Finger or Toe
Y	N	High or Low Blood Pressure	Y	N	Feet Problems
Y	N	Shortness of Breath	Y	N	Back Problems
Y	N	Pain or Pressure in the Chest	Y	N	Heart Problems
Y	N	Frequent Nose Bleeds	Y	N	Motion Sickness
Y	N	Frequent Sore Throat	Y	N	Recent Weight Loss or Weight Gain
Y	N	Seizures	Y	N	Frequent Trouble Sleeping
Y	N	Heat Illness	Y	N	

Explanation of “Y” Answers:

Health History Questionnaire

Current Weight: _____ Highest Weight (in past yr): _____ Lowest Weight (in past yr): _____

Record Serious injuries and/or surgeries in the **last year** – **be specific and give dates**. If none, mark **N/A**

Eyes, Ears, Nose and Throat: _____

Head: _____

Neck & Spine: _____

Chest: _____

Abdomen: _____

Upper Extremity: _____

Lower Extremity: _____

List any and all medications you are presently taking and why (if none, write **NONE**):

1. _____

2. _____

3. _____

Do you wear corrective lenses? Contact Lenses: Y N Glasses: Y N

Y N Has a physician ever denied or restricted your participation in sports for any reason? If yes, please **EXPLAIN**:

Parents Name: _____

Parents Address: _____

Parents Phone: _____

I have completely disclosed all pertinent information to the best of my knowledge. I also accept the responsibility for reporting all of my injuries and illnesses to the _____ athletic staff including signs and symptoms of concussions.

Student-Athlete's Signature: _____ **Date:** _____