

do not staple forms together

**2. Have you ever had, or do you currently have, any of the following *head-related* conditions:**

- |   |                    |
|---|--------------------|
| a. Concussion or head injury (including "bell rung" or a "ding")? | Y / N / Don't Know |
| b. Memory loss?   | Y / N / Don't Know |
| c. Knocked out?   | Y / N / Don't Know |
| c. A seizure?   | Y / N / Don't Know |
| d. Frequent or severe headaches (With or without exercise)?       | Y / N / Don't Know |
| e. Fuzzy or blurry vision   | Y / N / Don't Know |
| f. Sensitivity to light/noise                                     | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

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**3. Have you ever had, or do you currently have, any of the following *heart-related* conditions:**

- |  |                    |
|--|--------------------|
| a. Restriction from sports for heart problems?   | Y / N / Don't Know |
| b. Chest pain or discomfort?   | Y / N / Don't Know |
| c. Heart murmur?   | Y / N / Don't Know |
| d. High blood pressure?  | Y / N / Don't Know |
| e. Elevated cholesterol level?   | Y / N / Don't Know |
| f. Heart infection?  | Y / N / Don't Know |
| g. Dizziness or passing out during or after exercise without known cause?                        | Y / N / Don't Know |
| h. Has a provider ever ordered a heart test ( EKG, echocardiogram, stress test, Holter monitor)? | Y / N / Don't Know |
| i. Racing or skipped heartbeats?   | Y / N / Don't Know |
| j. Unexplained difficulty breathing or fatigue during exercise?                                  | Y / N / Don't Know |
| k. Any family member (blood relative):   |                    |
| (1.) Under age 50 with a heart condition?  | Y / N / Don't Know |
| (2.) With Marfan Syndrome?   | Y / N / Don't Know |
| (3.) Died of a heart problem before age 50? If yes, at what age? _____                           | Y / N / Don't Know |
| (4.) Died with no known reason?  | Y / N / Don't Know |
| (5.) Died while exercising? If yes, was it during or after? (Circle one.)                        | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

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**4. Have you ever had, or do you currently have, any of the following *eye, ear, nose, mouth or throat* conditions:**

- |   |                    |
|---|--------------------|
| a. Vision problems?   | Y / N / Don't Know |
| (1.) Wear contacts, eyeglasses or protective eye wear? (Circle which type.) | Y / N / Don't Know |
| b. Hearing loss or problems?  | Y / N / Don't Know |
| (1.) Wear hearing aides or implants?  | Y / N / Don't Know |
| c. Nasal fractures or frequent nose bleeds?                                 | Y / N / Don't Know |
| d. Wear braces, retainer or protective mouth gear?                          | Y / N / Don't Know |
| e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

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**5. Have you ever had, or do you currently have, any of the following *neuromuscular/orthopedic* conditions:**

- |   |                    |
|---|--------------------|
| a. Numbness, a "burner", "stinger" or pinched nerve?      | Y / N / Don't Know |
| b. A sprain?  | Y / N / Don't Know |
| c. A strain?  | Y / N / Don't Know |
| d. Swelling or pain in muscles, tendons, bones or joints? | Y / N / Don't Know |
| e. Dislocated joint(s)?                                   | Y / N / Don't Know |
| f. Upper or lower back pain?                              | Y / N / Don't Know |
| g. Fracture(s), stress fracture(s), or broken bone(s)?    | Y / N / Don't Know |
| h. Do you wear any protective braces or equipment?        | Y / N / Don't Know |

Explain all (yes) answers here (include relevant dates):

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Student's Name: \_\_\_\_\_

6. Have you ever had or do you currently have any of the following *general or exercise related conditions*:

- |   |                    |
|---|--------------------|
| a. Difficulty breathing?  |                    |
| (1.) During exercise?   | Y / N / Don't Know |
| (2.) After running one mile?  | Y / N / Don't Know |
| (3.) Coughing, wheezing or shortness of breath in weather changes?              | Y / N / Don't Know |
| (4.) Exercise-induced asthma?   | Y / N / Don't Know |
| i. Controlled with medication? (specify _____)                                  | Y / N / Don't Know |
| ii. Experience dizziness, passing out or fainting?                              | Y / N / Don't Know |
| b. Viral infections (e.g. mono, hepatitis, coxsackie virus)?                    | Y / N / Don't Know |
| c. Become tired more quickly than others?                                       | Y / N / Don't Know |
| d. Any of the following skin conditions:  |                    |
| (1.) Cold sores/herpes, impetigo, MRSA, ringworm, warts?                        | Y / N / Don't Know |
| (2.) Sun sensitivity?   | Y / N / Don't Know |
| e. Weight gain/loss (of 10 pounds or more)?                                     | Y / N / Don't Know |
| (1.) Do you want to weigh more or less than you do now?                         | Y / N / Don't Know |
| f. Ever had feelings of depression?   | Y / N / Don't Know |
| g. Heat-related problems (dehydration, dizziness, fatigue, headache)?           | Y / N / Don't Know |
| (1.) Heat exhaustion (cool, clammy, damp skin)?                                 | Y / N / Don't Know |
| (2.) Heat stroke (hot, red, dry skin)?  | Y / N / Don't Know |
| (3.) Muscle cramps?   | Y / N / Don't Know |
| h. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)? | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. **Females only:**

Age of onset of menstruation: \_\_\_\_\_ How many menstrual periods in the last twelve (12) months? \_\_\_\_\_

How many periods missed in the last twelve (12) months? \_\_\_\_\_

8. **Males only:**

Have you had any swelling or pain in your testicles or groin? Y / N / Don't Know

PARENT/GUARDIAN SIGNATURE

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

\_\_\_\_\_  
Signature, Parent/Guardian or Student Age 18

\_\_\_\_\_  
Date of Signature:

**THIS COMPLETED AND SIGNED HEALTH HISTORY MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAM.**