

# Health History Form

Athletic Medical Examination for \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ (sport) Birth date \_\_\_\_\_

Address \_\_\_\_\_ (street) \_\_\_\_\_ (city) \_\_\_\_\_ (zip) Phone \_\_\_\_\_

## Instructions

All questions must be answered. Failure to disclose pertinent medical information may invalidate your insurance coverage and may cancel your eligibility to participate in interscholastic athletics. Any further health problems must be discussed with the physician at the time of this examination.

## Medical History

Have you ever had any of the following? If "yes," give details to the examining doctor.

	No	Yes	Details (if answered yes)
1. Head injury or concussion	_____	_____	_____
2. Bone or joint disorders, fractures, dislocations, trick joints, arthritis, or back pain	_____	_____	_____
3. Eye or ear problems (disease or surgery)	_____	_____	_____
4. Heat illness	_____	_____	_____
5. Dizzy spells, fainting, or convulsions	_____	_____	_____
6. Tuberculosis, asthma, or bronchitis	_____	_____	_____
7. Heart trouble or rheumatic fever	_____	_____	_____
8. High or low blood pressure	_____	_____	_____
9. Anemia, leukemia, or bleeding disorder	_____	_____	_____
10. Diabetes, hepatitis, or jaundice	_____	_____	_____
11. Ulcers, other stomach trouble, or colitis	_____	_____	_____
12. Kidney or bladder problems	_____	_____	_____
13. Hernia (rupture)	_____	_____	_____
14. Mental illness or nervous breakdown	_____	_____	_____
15. Addiction to drugs or alcohol	_____	_____	_____
16. Surgery or advised to have surgery	_____	_____	_____
17. Taking medication regularly	_____	_____	_____
18. Allergies or skin problems	_____	_____	_____
19. Menstrual problems; LMP	_____	_____	_____

Signature \_\_\_\_\_ Date \_\_\_\_\_