Name:_____ Sport:_____ Date:_____

Date of Birth:_____ Social Security Number:_____

Please answer each of the following questions by checking either the "yes" or "no" box.
Explain any "yes" answers in the space provided.

Family History

Has any parent, grandparent, or sibling had:

Cancer	[ ] YES [ ] NO	_____
Leukemia	[ ] YES [ ] NO	_____
Tuberculosis	[ ] YES [ ] NO	_____
Diabetes	[ ] YES [ ] NO	_____
Heart trouble	[ ] YES [ ] NO	_____
High blood pressure	[ ] YES [ ] NO	_____
Asthma	[ ] YES [ ] NO	_____
Liver disease	[ ] YES [ ] NO	_____
Migraine headaches	[ ] YES [ ] NO	_____
Emphysema	[ ] YES [ ] NO	_____
Stroke	[ ] YES [ ] NO	_____
Epilepsy	[ ] YES [ ] NO	_____
Stroke	[ ] YES [ ] NO	_____
Bleeding Disorder	[ ] YES [ ] NO	_____
Kidney disease	[ ] YES [ ] NO	_____
Glaucoma	[ ] YES [ ] NO	_____
Sickle Cell Anemia	[ ] YES [ ] NO	_____
Other serious disease	[ ] YES [ ] NO	_____
Sudden death before age 50	[ ] YES [ ] NO	_____

Personal History

Do you smoke?	[ ] YES [ ] NO	_____
Do you use other tobacco products?	[ ] YES [ ] NO	_____
Do you drink alcohol?	[ ] YES [ ] NO	_____
Does alcohol affect school?	[ ] YES [ ] NO	_____
Received treatment for substance abuse?	[ ] YES [ ] NO	_____
Are you on a special diet?	[ ] YES [ ] NO	_____
Have you recently lost weight?	[ ] YES [ ] NO	_____
Are you unsatisfied with your weight?	[ ] YES [ ] NO	_____
Ever diagnosed with an eating disorder?	[ ] YES [ ] NO	_____
Do you have difficultly sleeping?	[ ] YES [ ] NO	_____

Allergies

Latex	[ ] YES [ ] NO	_____
Penicillin/ other antibiotics	[ ] YES [ ] NO	_____
Sulfa drugs	[ ] YES [ ] NO	_____
Other drug/medicine	[ ] YES [ ] NO	_____
Any food item	[ ] YES [ ] NO	_____
Bee Stings	[ ] YES [ ] NO	_____
Other allergy	[ ] YES [ ] NO	_____

Medications

Current tetanus vaccination	[ ] YES [ ] NO	give date of last vaccination:_____
Are you currently taking medications?	[ ] YES [ ] NO	_____

Have you ever taken:

Thyroid medicine	[ ] YES [ ] NO	_____
Blood pressure medicine	[ ] YES [ ] NO	_____
Birth control pills	[ ] YES [ ] NO	_____
Other medication	[ ] YES [ ] NO	_____

Current Health Status

MUSCULOSKELETAL

Have you ever suffered a sprain, strain, dislocation, fracture or other injury to any of the following? Please give dates of injury and surgery information if applicable.

Neck injury	[ ] YES [ ] NO	_____
Shoulder injury	[ ] YES [ ] NO	_____
Elbow injury	[ ] YES [ ] NO	_____
Wrist/hand injury	[ ] YES [ ] NO	_____
Back injury	[ ] YES [ ] NO	_____
Hip injury	[ ] YES [ ] NO	_____
Knee injury	[ ] YES [ ] NO	_____
Ankle/foot injury	[ ] YES [ ] NO	_____
Broken bone	[ ] YES [ ] NO	_____
Stress fracture	[ ] YES [ ] NO	_____
Other musculoskeletal problem	[ ] YES [ ] NO	_____

Do you now, or have you had in the past any of the following?

Musculoskeletal

Arthritis	[ ] YES [ ] NO	_____
Swollen joints	[ ] YES [ ] NO	_____
Loss of muscle strength	[ ] YES [ ] NO	_____
Lump or swelling in muscle	[ ] YES [ ] NO	_____

SYSTEMIC

General

Diabetes	[ ] YES [ ] NO	_____
Controlled with insulin	[ ] YES [ ] NO	_____
Thyroid disorder	[ ] YES [ ] NO	_____
Hepatitis	[ ] YES [ ] NO	_____
Anemia	[ ] YES [ ] NO	_____
Sickle cell anemia	[ ] YES [ ] NO	_____
Epilepsy/convulsions	[ ] YES [ ] NO	_____
Rheumatic Fever	[ ] YES [ ] NO	_____
Mononucleosis	[ ] YES [ ] NO	_____
Poor blood clotting	[ ] YES [ ] NO	_____
Fever	[ ] YES [ ] NO	_____
Chills	[ ] YES [ ] NO	_____
Aches and Pains	[ ] YES [ ] NO	_____
General weakness	[ ] YES [ ] NO	_____
Memory loss	[ ] YES [ ] NO	_____
Swollen Glands	[ ] YES [ ] NO	_____
Easy bruising	[ ] YES [ ] NO	_____

Heat Related Illness

Dehydration	[ ] YES [ ] NO	_____
Heat cramps	[ ] YES [ ] NO	_____
Heat exhaustion	[ ] YES [ ] NO	_____
Heat stroke	[ ] YES [ ] NO	_____
Have you ever:		
Felt dizzy during/after exercise	[ ] YES [ ] NO	_____
Passed out during/after exercise	[ ] YES [ ] NO	_____
Had muscle cramps	[ ] YES [ ] NO	_____

Head

Hay fever/Allergies	[ ] YES [ ] NO	_____
Concussion	[ ] YES [ ] NO	_____
Migraine headaches	[ ] YES [ ] NO	_____
Severe headaches	[ ] YES [ ] NO	_____
Face fracture	[ ] YES [ ] NO	_____
Other head problem	[ ] YES [ ] NO	_____

Eyes

Contacts or glasses	[ ] YES [ ] NO	_____
Glaucoma	[ ] YES [ ] NO	_____
Cataracts	[ ] YES [ ] NO	_____
Blindness (either eye)	[ ] YES [ ] NO	_____
Blurred vision not corrected with lenses	[ ] YES [ ] NO	_____
Double Vision	[ ] YES [ ] NO	_____
Light flashes	[ ] YES [ ] NO	_____
Halos around lights	[ ] YES [ ] NO	_____
Pain in your eyes	[ ] YES [ ] NO	_____
Eye fracture	[ ] YES [ ] NO	_____
Other eye problem	[ ] YES [ ] NO	_____

Ears

Ear infections	[ ] YES [ ] NO	_____
Ear pain	[ ] YES [ ] NO	_____
Drainage from ear	[ ] YES [ ] NO	_____
Hearing difficulty or deafness	[ ] YES [ ] NO	_____
Buzzing/ringing ears	[ ] YES [ ] NO	_____
Other ear problem	[ ] YES [ ] NO	_____

Mouth/Nose

Nosebleeds	[ ] YES [ ] NO	_____
Nose fracture	[ ] YES [ ] NO	_____
Sinus trouble	[ ] YES [ ] NO	_____
Difficulty with swallowing	[ ] YES [ ] NO	_____
False teeth or bridges	[ ] YES [ ] NO	_____
Fractured or loose tooth	[ ] YES [ ] NO	_____
Mouth, tooth, or tongue problem	[ ] YES [ ] NO	_____
Other mouth/nose problem	[ ] YES [ ] NO	_____

Neck

Swelling	[ ] YES [ ] NO	_____
Lumps	[ ] YES [ ] NO	_____
Stiffness	[ ] YES [ ] NO	_____
Burner or stinger	[ ] YES [ ] NO	_____
Neck fracture	[ ] YES [ ] NO	_____
Other neck problem	[ ] YES [ ] NO	_____

Skin

Recurrent boils	[ ] YES [ ] NO	_____
Changing mole	[ ] YES [ ] NO	_____
Rash	[ ] YES [ ] NO	_____
Yellow skin	[ ] YES [ ] NO	_____
Other skin problem	[ ] YES [ ] NO	_____

Chest, Heart and Lungs

Asthma	[ ] YES [ ] NO	_____
Controlled with medication	[ ] YES [ ] NO	_____
Chronic Bronchitis	[ ] YES [ ] NO	_____
Tuberculosis	[ ] YES [ ] NO	_____
Shortness of breath	[ ] YES [ ] NO	_____
Poor exercise tolerance	[ ] YES [ ] NO	_____
High blood pressure	[ ] YES [ ] NO	_____
Heart murmur	[ ] YES [ ] NO	_____
Unusual heartbeat	[ ] YES [ ] NO	_____
Chest pains or pressure attacks	[ ] YES [ ] NO	_____
Frequent cough	[ ] YES [ ] NO	_____
Coughing up blood	[ ] YES [ ] NO	_____
Wheezing	[ ] YES [ ] NO	_____
Night sweats	[ ] YES [ ] NO	_____
Swollen ankles	[ ] YES [ ] NO	_____
Leg cramps	[ ] YES [ ] NO	_____
Other chest problem	[ ] YES [ ] NO	_____
Other heart problem	[ ] YES [ ] NO	_____
Other lung problem	[ ] YES [ ] NO	_____

Gastrointestinal

Indigestion or heartburn	[ ] YES [ ] NO	_____
Stomach or Duodenal Ulcer	[ ] YES [ ] NO	_____
Colon trouble	[ ] YES [ ] NO	_____
Rectal trouble	[ ] YES [ ] NO	_____
Poor appetite	[ ] YES [ ] NO	_____
Nausea/vomiting	[ ] YES [ ] NO	_____
Abdominal pain or cramps	[ ] YES [ ] NO	_____
Change in bowel habits	[ ] YES [ ] NO	_____
Blood in stool	[ ] YES [ ] NO	_____
Other gastrointestinal problem	[ ] YES [ ] NO	_____

Neuromuscular

Weakness in arm or leg	[ ] YES [ ] NO	_____
Numbness in arm or leg	[ ] YES [ ] NO	_____
Tingling in arm or leg	[ ] YES [ ] NO	_____
Balance difficulty	[ ] YES [ ] NO	_____
Dizzy spells	[ ] YES [ ] NO	_____
Fainting spells	[ ] YES [ ] NO	_____
Speech difficulty	[ ] YES [ ] NO	_____
Other neuromuscular problem	[ ] YES [ ] NO	_____

Urinary

Bladder/Urinary tract infection	[ ] YES [ ] NO	_____
Kidney infection	[ ] YES [ ] NO	_____
Kidney stones	[ ] YES [ ] NO	_____
Loss of kidney	[ ] YES [ ] NO	_____
Other kidney disease	[ ] YES [ ] NO	_____

MALES ONLY

Lump in testicles	[ ] YES [ ] NO	_____
Loss of a testicle	[ ] YES [ ] NO	_____
Hernia	[ ] YES [ ] NO	_____
Other problem	[ ] YES [ ] NO	_____

FEMALES ONLY

Breast lump	[ ] YES [ ] NO	_____
Discharge from nipple	[ ] YES [ ] NO	_____
Other breast problem	[ ] YES [ ] NO	_____
Vaginal bleeding or spotting not associated with periods	[ ] YES [ ] NO	_____
Pain with periods	[ ] YES [ ] NO	_____
Change in periods	[ ] YES [ ] NO	_____
Irregular periods	[ ] YES [ ] NO	_____
Lack of periods	[ ] YES [ ] NO	_____
Ovarian cyst	[ ] YES [ ] NO	_____
Other GYN problems	[ ] YES [ ] NO	_____

Psychological

Serious depression	[ ] YES [ ] NO	_____
Serious emotional problem	[ ] YES [ ] NO	_____
Do you find your life:		
Generally unsatisfying	[ ] YES [ ] NO	_____
Too demanding	[ ] YES [ ] NO	_____
Boring	[ ] YES [ ] NO	_____
Do you worry about:		
Food	[ ] YES [ ] NO	_____
Money	[ ] YES [ ] NO	_____
School	[ ] YES [ ] NO	_____
Weight	[ ] YES [ ] NO	_____
Parents/family	[ ] YES [ ] NO	_____
Boyfriend/girlfriend	[ ] YES [ ] NO	_____
Do you:		
Often feel depressed	[ ] YES [ ] NO	_____
Cry easily	[ ] YES [ ] NO	_____
Feel inferior to others	[ ] YES [ ] NO	_____
Feel shy	[ ] YES [ ] NO	_____
Feel things often go wrong	[ ] YES [ ] NO	_____
Feel overstressed	[ ] YES [ ] NO	_____
Feel anxious or upset	[ ] YES [ ] NO	_____

Are you currently under the care of a physician for any injury or medical condition? [ ] YES [ ] NO
If yes, please explain:
Physician's name and phone number: _____
Injury or condition: _____
Current treatment: _____
_____
_____

Do you have any condition or disease not listed on this form? [ ] YES [ ] NO
If yes, please explain:
_____
_____
_____
_____
_____
_____

I, _____(print full name) the undersigned, herewith:

a. Understand that I must refrain from practice or play while ill or injured, whether or not receiving medical treatment until I am discharged from treatment or given permission by the Certified Athletic Trainer and/or Team Physician to restart participation despite continuing treatment.

b. Understand that having passed the physical examination does not necessarily mean that I am physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify at the time of said examination.

c. Give permission to the Athletic Training Staff and Team Physicians to discuss medical conditions pertaining to athletic participation.

d. Certify that the answers given to the questions above are correct and true to the best of my knowledge.

Athlete Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if athlete is under 18 years of age)

Reviewed by ATC: _____ Date: _____