

## Medical History

Since the date of your last preseason physical exam, have you had ANY of the following conditions?	YES	NO
1. Have you had any medical problems or injuries since your last physical?		
2. Do you have any ongoing or chronic illnesses (diabetes, sickle cell anemia, epilepsy, etc)?		
3. Have you been hospitalized or had surgery?		
4. Are you currently taking any prescription or non-prescription medication or using an inhaler?		
5. Do you take any supplements or vitamins?		
6. Have you passed out or been excessively dizzy during or after exercise?		
7. Have you had chest pain during or after exercise?		
8. Have you had high blood pressure?		
9. Have you been diagnosed with a heart murmur?		
10. Has a physician ever denied or restricted your participation in sports for any heart problems?		
11. Have you had any skin problems (itching, rash, acne, warts, fungus, etc.)?		
12. Have you had a head injury/concussion?		
13. Have you been knocked out, unconscious, or suffered memory loss?		
14. Have you had a seizure?		
15. Have you had frequent or severe headaches?		
16. Have you had numbness or tingling in your arm, legs, or feet?		
17. Have you had heat or muscle cramps?		
18. Have you had trouble breathing or do you cough during or after activity?		
19. Have you used any special equipment (pads, braces, mouth guard, foot orthotics, etc)?		
20. Have you had any problems with your eyes or vision?		
21. Do you wear glasses or contacts or protective eye-wear?		
22. Have you ever sprained, strained, fractured, dislocated, broken, or had repeated swelling to any bones or joints in the following areas (check all that apply and explain below): <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Chest <input type="checkbox"/> Back <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Knee		

➔ Explain "YES" answers:

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Reviewed by Athletic Training Staff: \_\_\_\_\_ Date: \_\_\_\_\_