HISTORY FORM
(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam ___________________________ Date of birth ___________________________

Name ___________________________ Sex ____________ Age ____________ Grade ____________ School ___________________________ Sport(s) ___________________________

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

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<tr>
<th>Medicines</th>
<th>Allergies</th>
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Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below. ☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

### GENERAL QUESTIONS

1. Has a doctor ever denied or restricted your participation in sports for any reason? Yes ☐ No ☐
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ___________________________
3. Have you ever spent the night in the hospital? Yes ☐ No ☐
4. Have you ever had surgery? Yes ☐ No ☐
5. Have you ever had an unexplained seizure? Yes ☐ No ☐
6. Have you ever been unable to move your arms or legs after being hit or falling? Yes ☐ No ☐
7. Do you have any allergies? Yes ☐ No ☐ If yes, please identify specific allergy below: ☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ Heart murmur ☐ High cholesterol ☐ Heart infection ☐ Kawasaki disease Other: ___________________________
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram) Yes ☐ No ☐
10. Do you feel tired or out of breath while exercising? Yes ☐ No ☐
11. Have you ever had an unexplained seizure? Yes ☐ No ☐
12. Do you get more tired or short of breath than your friends during exercise? Yes ☐ No ☐
13. Has a family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or unexpected death)? Yes ☐ No ☐
14. Has anyone in your family had unexplained fainting, unexplained syncope, or near drowning? Yes ☐ No ☐
15. Does anyone in your family have a heart problem, pacemaker, or other heart condition? Yes ☐ No ☐
16. Has anyone in your family had unexplained fainting, unexplained syncope, or near drowning? Yes ☐ No ☐

### MEDICAL QUESTIONS

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss practice or a game? Yes ☐ No ☐
18. Have you ever had any broken or fractured bones or dislocated joints? Yes ☐ No ☐
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? Yes ☐ No ☐
20. Have you ever had a stress fracture? Yes ☐ No ☐
21. Have you ever been told by a doctor that you have or have had an x-ray for neck instability or atlantoaxial instability? Yes ☐ No ☐
22. Do you regularly use a brace, orthotics, or other assistive device? Yes ☐ No ☐
23. Do you have a bone, muscle, or joint injury that bothers you? Yes ☐ No ☐
24. Do any of your joints become painful, swollen, feel warm, or look red? Yes ☐ No ☐
25. Have you ever had arthritis or other joint disease? Yes ☐ No ☐
26. Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes ☐ No ☐
27. Have you ever used an inhaler or taken asthma medicine? Yes ☐ No ☐
28. Is there anyone in your family who has asthma? Yes ☐ No ☐
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? Yes ☐ No ☐
30. Do you have groin pain or a painful bulge or hernia in the groin area? Yes ☐ No ☐
31. Have you had infectious mononucleosis (mono) within the last month? Yes ☐ No ☐
32. Do you have any rashes, pressure sores, or other skin problems? Yes ☐ No ☐
33. Have you had a heart infection or MRSA skin infection? Yes ☐ No ☐
34. Have you had a head injury or concussion? Yes ☐ No ☐
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? Yes ☐ No ☐
36. Do you have a history of seizure disorder? Yes ☐ No ☐
37. Do you have headaches with exercise? Yes ☐ No ☐
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? Yes ☐ No ☐
39. Have you ever been unable to move your arms or legs after being hit or falling? Yes ☐ No ☐
40. Have you ever become ill while exercising in the heat? Yes ☐ No ☐
41. Do you get frequent muscle cramps when exercising? Yes ☐ No ☐
42. Do you or someone in your family have sickle cell trait or disease? Yes ☐ No ☐
43. Have you had any problems with your eyes or vision? Yes ☐ No ☐
44. Have you had any eye injuries? Yes ☐ No ☐
45. Do you wear glasses or contact lenses? Yes ☐ No ☐
46. Do you wear protective eyewear, such as goggles or a face shield? Yes ☐ No ☐
47. Do you worry about your weight? Yes ☐ No ☐
48. Are you on a special diet or do you avoid certain types of foods? Yes ☐ No ☐
49. Have you had a heart infection or MRSA skin infection? Yes ☐ No ☐
50. Have you ever had an eating disorder? Yes ☐ No ☐
51. Do you have any concerns that you would like to discuss with a doctor? Yes ☐ No ☐

### FEMALES ONLY

52. Have you ever had a menstrual period? Yes ☐ No ☐
53. How old were you when you had your first menstrual period? Yes ☐ No ☐
54. How many periods have you had in the last 12 months? Yes ☐ No ☐

Explain "yes" answers here:

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I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ___________________________ Signature of parent/guardian ___________________________ Date ___________________________


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