Pre-Participation Medical History

NAME: ____ DATE: ________________

Please complete the following:

	Yes	No
1. Have you ever had a prolonged medical illness:	_____	_____
2. Have you ever had surgery?	_____	_____
3. Are you currently taking any prescription or nonprescription medications?	_____	_____
4. Are you currently taking supplements or vitamins?	_____	_____
5. Have you ever been told that you cannot or should not participate in a sport or exercise for a medical reason?	_____	_____
6. When was your last Tetanus immunization?	_________________	
7. Do you have drug allergies?	_____	_____
8. Do you have food allergies?	_____	_____
9. Are you allergic to stinging insects?	_____	_____
10. Have you ever had a rash or hives develop during or immediately after exercising?	_____	_____
11. Do you have recurring skin conditions?	_____	_____
12. Do you cough, wheeze, or have trouble breathing during or after exercise?	_____	_____
13. Do you have asthma?	_____	_____
14. Do you have seasonal allergies that require medical treatment?	_____	_____
15. Have you ever passed out during or after exercise?	_____	_____
16. Have you ever experienced excessive dizziness during or after exercise?	_____	_____
17. Have you ever had chest pains during or after exercise?	_____	_____
18. Do you tire quickly during activity?	_____	_____
19. Does your heart frequently race or skip beats?	_____	_____
20. Do you have hypertension or high cholesterol?	_____	_____
21. Do you have a heart murmur?	_____	_____
22. Have you had a severe viral infection (myocarditis or mononucleosis) within the last month?	_____	_____
23. Has a doctor ever denied or restricted your participation in sports for any heart problems?	_____	_____
24. Have you ever become ill after exercising in the heat?	_____	_____
25. Have you ever had severe muscle cramps during activity?	_____	_____
26. Have you ever received IV fluids for a heat illness?	_____	_____
27. Have you ever had a head injury or concussion?	_____	_____
28. Have you ever been knocked out, become unconscious, or lost your memory?	_____	_____
29. Have you ever had a seizure?	_____	_____
30. Do you have frequent or severe headaches?	_____	_____

	Yes	No
31. Have you ever had numbess or tingling in your arms, hands, legs, or feet?	_____	_____
32. Have you ever had a stinger, burner, or pinched nerve?	_____	_____
33. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (knee braces, special neck roll, foot orthotics, dental appliances, or hearing aid)?	_____	_____
34. Have you had any problems with your eyes or vision?	_____	_____
35. Do you wear glasses, contacts, or protective eyewear?	_____	_____
36. Do you wear any dental appliance, dentures, or partials?	_____	_____
37. Do you regularly gain or lose weight to meet the requirements for an activity?	_____	_____
38. Do you have any medical problems that have not been mentioned above?	_____	_____
38. When was your first menstrual period?	_____	_____
39. What was your most recent menstrual period?	_____	_____

40. How many days are there from the start of one period to the start of another? _____ days

41. How many periods have you had in the past year? _______________periods

42. What was the approximate longest time between periods last year _____days

Please provide explanations for any item with a "Yes" answer:

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