HISTORY

Yes  No

1. a. □ □ Have you had any illness/injury recently, or do you have an illness/injury now?
   b. □ □ Have you had a medical problem, illness or injury since your last exam?
   c. □ □ Do you have any chronic or recurrent illness?
   d. □ □ Have you ever had any illness lasting more than a week?
   e. □ □ Have you ever been hospitalized overnight?
   f. □ □ Have you had any surgery other than tonsillectomy?
   g. □ □ Have you ever had any injuries requiring treatment by a physician?
   h. □ □ Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)?

2. □ □ Are you presently taking ANY medications (including birth control pill, vitamin, aspirin, etc.)?

3. □ □ Do you have ANY allergies (medicines, bees, foods, or other factors)?

4. a. □ □ Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?
   b. □ □ Do you tire more easily or quickly than your friends during exercise?
   c. □ □ Have you ever had any problem with your blood pressure or your heart?
   d. □ □ Have any close relatives had heart problems, heart attack or sudden death before they were age 50?

5. □ □ Do you have any skin problems (acne, itching, rashes, etc.)?

6. a. □ □ Have you ever had fainting, convulsions, seizures or severe dizziness?
   b. □ □ Do you have frequent severe headaches?
   c. □ □ Have you ever had a “stinger” or “burner” or “pinched nerve”?
   d. □ □ Have you ever been “knocked out” or “passed out”?
   e. □ □ Have you ever had a neck or head injury?

7. □ □ Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems?

8. □ □ Have you had asthma, or trouble breathing, or cough during or after exercise?

9. a. □ □ Do you wear eyeglasses, contact lenses or protective eye wear?
   b. □ □ Have you had any problem with your eyes or vision?

10. □ □ Do you wear any dental appliance such as braces, bridge, plate, retainer?

11. a. □ □ Have you ever had a knee injury?
    b. □ □ Have you ever had an ankle injury?
    c. □ □ Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?
    d. □ □ Have you ever had a broken bone (fracture)?
    e. □ □ Have you ever had a cast, splint, or had to use crutches?
    f. □ □ Must you use special equipment for competition (pads, braces, neck roll, etc.)?

12. □ □ Has it been more than 5 years since your last tetanus booster shot?

13. □ □ Are you worried about your weight?

14. □ □ FEMALES: Have you any menstrual problems?

15. □ □ Have you any medical concerns about participating in your sport?

***** ATHLETE SHOULD NOT WRITE BELOW THIS LINE *****

EXAMINER’S COMMENTS ON ALL “YES” ANSWERS (refer to question number):