Health Questionnaire
Pre-participation

Name_____Sex_____Age_____Date of birth_____

Grade_____School_____Sport_____

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

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or non-prescription (over the counter) medications or pills?	☐	☐
4. Do you have any allergies? (ie., medicines, pollens, latex, foods, or stinging insects?	☐	☐
5. Do you have an Epi-Pen?	☐	☐
6. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
7. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
8. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
9. Does your heart race or skip beats during exercise?	☐	☐
10. Has a doctor ever told you that you have (check all that apply): ☐high blood pressure ☐a heart murmur ☐high cholesterol ☐a heart infection		
11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	☐	☐
12. Has anyone in your family died for no apparent reason?	☐	☐
13. Does anyone in your family have a heart problem?	☐	☐
14. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
15. Have you ever had surgery?	☐	☐
16. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below:	☐	☐
17. Have you had any broken or fractured bones or dis-located joints? If yes, circle below:	☐	☐
18. Have you had a bone or joint injury that required xrays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, cast, or crutches? If yes, circle below:	☐	☐
19. Have you ever had a stress fracture?	☐	☐
20. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
21. Do you regularly use a brace or assistive device?	☐	☐
22. Has a doctor ever told you that you have asthma or allergies?	☐	☐
23. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
24. Is there anyone in your family who has asthma?	☐	☐
25. Have you ever used an inhaler or taken asthma medicine?	☐	☐
26. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
27. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
28. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
29. Have you had a herpes or staph skin infection?	☐	☐
30. Have you ever had a head injury or concussion?	☐	☐
31. Have you been hit in the head and been confused or lost your memory?	☐	☐
32. Have you ever had a seizure?	☐	☐
33. Do you have headaches with exercise?	☐	☐
34. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
35. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
36. Have you had any problems with your eyes or vision?	☐	☐
37. Do you wear glasses or contact lenses?	☐	☐
38. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
39. Are you trying to gain or lose weight?	☐	☐
40. Has anyone recommended you change your weight or eating habits?	☐	☐
41. Do you limit or carefully control what you eat?	☐	☐

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/ toes

Explain ALL "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_____

**It is your responsibility, as a parent/guardian, to inform the school's office staff, in writing, if any personal information regarding your child has changed.