

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

Explain ALL "Yes" answers here: _____

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

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 _____