

ALLENTOWN CENTRAL CATHOLIC HIGH SCHOOL
MEDICAL HISTORY QUESTIONNAIRE

***** ANSWER ALL QUESTIONS *****

Name: _____ Year: Fr So Jr Sr Sex: M F Age: _____

Sport(s): _____ Date of Birth: ___/___/___ Phone: (____)____-____
(List all sports)

Street: _____ City: _____ Zip: _____

Emergency Contact : (Please list one)

Name: _____

Relation: _____

Phone: _____ (other than home phone)

Primary insurance: (other than school) _____

Family Physician: _____

EXPLAIN ALL "YES" ANSWERS BELOW

Have you ever been hospitalized?

Yes No

Have you ever had surgery?

Yes No

Do you have any allergies? (medicine, bees, or other biting insects)

Yes No

Have you ever passed out during or after exercise?

Yes No

Have you ever been dizzy during or after exercise?

Yes No

Have you ever had chest pain during exercise?

Yes No

Do you tire more quickly than your friends during exercise?

Yes No

Have you ever had high blood pressure?

Yes No

Have you ever been told you had a heart murmur?

Yes No

Have you ever had racing of your heart or skipped heart beats?

Yes No

Has anyone in our family died of heart problems or sudden death before the age of 50?

Yes No

Do you have any skin problems (itching, rashes, acne)?

Yes No

Have you ever had a head injury (concussion)?

Yes No

Have you ever been knocked out or unconscious?

Yes No

Have you ever had a seizure?

Yes No

Have you ever had a stinger, burner, or pinched nerve?

Yes No

Have you ever had heat or muscle cramps?

Yes No

Have you ever been dizzy or passed out in the heat?

Yes No

Do you have trouble breathing or do you cough after your activity?

Yes No

Do you use any special equipment (braces, neck rolls, mouth guards, eye guards, etc.)?

Yes No

Do you have any problems with you eyes or vision?

Yes No

Do you wear glasses, contacts, or protective eye wear?

Yes No

Have you ever sprained/strained, dislocated, fractured, broken, or has repeated swelling or other injuries of any bones or joints?

Yes No

If Yes, where? (circle and specify injury below)

Head	Shoulder	Thigh	Neck	Knee	Chest	Forearm
Shin/Calf	Back	Wrist	Hand	Foot	Hip	

Have you ever had any other medical problems (infectious mononucleosis, diabetes, etc.)?

Yes No

Have you had a medical problem or injury since your last evaluation?

Yes No

Do you have a tendency to bleed easily?

Yes No

Do you take any medications regularly?

Yes No

When was your last tetanus shot? _____

Males Only:

Have you had or do you have loss of function of testicle(s) ?

Yes No

Females Only:

At what age was you first menstrual period? _____

Have you had or do you have menstrual problems?

Yes No

Do you smoke?

Yes No

Have you ever been told to give up sports because of a health problem?

Yes No

Explain all Yes answers here: _____

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

Date: _____

Signature of athlete: _____

Signature of parent: _____