

# HEALTH HISTORY

*Please Circle YES or NO for each answer. Please explain all YES answers.*

YES NO Do you wish to speak with a doctor about a past or current health problem?

YES NO Have you ever been told to give up an activity because of health?

YES NO Do you have an absence or nonfunctioning or one of a set of paired organs?  
(EX: kidneys, eyes, ovaries, testes)

YES NO Has anyone in your family died suddenly before the age of 50?  
If yes, please explain.

YES NO Have you ever had surgery?  
If yes, please explain.

What is your blood type?      A      AB      B      O      Positive or Negative?

YES NO Have you had any illness requiring bed rest of one week or longer during the past year?  
If yes, please explain.

## **Have you ever been diagnosed as having:**

YES NO Heart murmur?

YES NO Sickle cell trait or sickle cell anemia?

YES NO Epilepsy? If yes, when was the date of your most recent seizure? \_\_\_\_\_

YES NO Diabetes? If yes, how do you control your condition? \_\_\_\_\_

YES NO Asthma? If yes, exercise- or allergy-induced?  
Do you use an inhaler for athletic participation? Name: \_\_\_\_\_

YES NO Have you ever suffered from an asthma attack requiring medical attention?

YES NO Mononucleosis? If yes, when? \_\_\_\_\_

YES NO Any type of infectious disease, such as staph or MRSA?

YES NO Diagnosed as HIV-positive?

**Have you ever experienced:**

- YES NO Chest pain with exercise? If yes, date: \_\_\_\_\_
- YES NO Dizziness or faintness with exercise? If yes, date: \_\_\_\_\_
- YES NO Shortness of breath with exercise? If yes, date: \_\_\_\_\_
- YES NO Heat exhaustion or heat stroke? If yes, date: \_\_\_\_\_
- YES NO Do you have impaired vision in one or both eyes? If yes, which eye(s)? \_\_\_\_\_
- YES NO Have you ever experienced temporary loss of vision? If yes, date? \_\_\_\_\_
- YES NO Do you wear sports goggles or contacts?  
If contacts, what kind? \_\_\_\_\_
- YES NO Do you have an extra pair of contacts?
- YES NO Do you have impaired hearing in one or both ears? If yes, which ear(s)? \_\_\_\_\_
- YES NO Have you ever perforated/burst your eardrum? If yes, which ear(s)? \_\_\_\_\_
- YES NO Do you suffer from recurrent sinus infections?
- YES NO Do you wear any dental appliances? If yes, what? \_\_\_\_\_
- YES NO Have you ever had a head injury that included loss of consciousness?  
If yes, when and what sport? \_\_\_\_\_
- YES NO Were you admitted to the hospital as a result of that injury?

How many times have you suffered a concussion and how many times have you suffered a loss of consciousness? \_\_\_\_\_

**Have you ever had:**

- YES NO Skull fracture? If yes, when: \_\_\_\_\_
- YES NO Brachial plexus/stinger? If yes, when and what sport: \_\_\_\_\_
- YES NO Do you suffer from recurrent or migraine headaches? Most recent? \_\_\_\_\_
- YES NO Have you ever had a bone fracture, stress fracture, bone infection, bone tumor, blood clots/clotting disorder, graft, or spinal fusion? Please explain ALL if yes: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

YES NO Have you ever been diagnosed as having a spinal deformity, such as scoliosis, herniated discs, chondromalacia of the knee, Osgood-Schlatters, myositis ossificans, tendonitis, or bursitis? Please explain location if yes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

YES NO Do you have a pin, screw, or plate anywhere in your body?  
If yes, please list location and date of surgery: \_\_\_\_\_

YES NO Do you suffer from recurrent boils, skin infections, athlete's foot, hemorrhoids, recurrent rashes, or hives?

YES NO Are you allergic to bee stings or suffer any other allergies? If yes, please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

YES NO Do you wish to discuss an emotional problem with a counselor or clinician?

YES NO Do you take any medication on a regular basis? If yes, please list and the reason for:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

YES NO Do you require any type of medication for emergency use? If so, please list and the reason for: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

YES NO Are you allergic to any medication? Please list: \_\_\_\_\_  
\_\_\_\_\_

**WOMEN ONLY**

YES NO Do you have any problems associated with your menstrual cycle (cramping, irregularity, etc)? \_\_\_\_\_

**All the above questions have been answered completely, truthfully, and to the best of my knowledge.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*The information contained in this form is strictly confidential. It will be used solely by the Northwood University Sports Medicine Staff and will not be released without your knowledge or consent.*