

PRE-SEASON ATHLETIC SCREENING

Name _____ Date _____

Social Security# _____ Date of Birth _____ Sex (circle) Female Male

School _____ Sport _____ Year in School _____

Address _____

City/State/Zip _____

Home Phone _____ Cell Phone _____

Parent/Guardian Name _____

FAMILY HISTORY (check appropriate Yes or No answers) *PLEASE ANSWER ALL QUESTIONS*

Have you or anyone in your immediate family had?...

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Asthma, Hives, Hayfever	___	___	Migraine	___	___	Heart Attack	___	___
Arthritis	___	___	Sickle Cell/Anemia	___	___	Strokes	___	___
Seizures/Convulsions	___	___	High Blood Pressure	___	___	Epilepsy	___	___
Diabetes	___	___	Knee Problems	___	___			

Explain "Yes" answers _____

PERSONAL MEDICAL HISTORY (check appropriate Yes or No answers)

Are you currently taking medication? (please circle) YES NO

Are you allergic to?...

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Bee Sting	___	___	Penicillin	___	___	Codeine	___	___
Adhesive Tape	___	___	Morphine	___	___	Aspirin	___	___
						Tetanus	___	___
						Mycins	___	___

Explain "Yes" answers _____

Do you wear? (please circle and explain)

Eyeglasses contact lenses dentures dental braces bridgework false eye

Explain _____

SYSTEMS HISTORY (check appropriate Yes or No answers) *PLEASE ANSWER ALL QUESTIONS*

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Irregular Pulse	___	___	Jaundice	___	___	Heart Murmurs	___	___
Mononucleosis	___	___	Enlarged Liver	___	___	Hernia	___	___
Menstrual Disorder	___	___	One Testicle	___	___	Ulcers	___	___
Enlarged Spleen	___	___	Thyroid Disease	___	___	Heat Illness	___	___
Tuberculosis	___	___	One Working Ovary	___	___	Hospitalized	___	___
						One Kidney	___	___

Explain "Yes" answers _____

INJURY HISTORY (check appropriate Yes or No answers)

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Pinched Nerve	___	___	Separated Shoulder R/L	___	___	Knee Injury R/L	___	___
Skull Fracture	___	___	Foot Injury R/L	___	___	Ankle Injury R/L	___	___
Concussion	___	___	Head Injury	___	___	Hand Injury R/L	___	___
Back Injury	___	___	Neck Injury	___	___	Broken Bone	___	___

Explain "Yes" answers _____

ATHLETE'S SIGNATURE _____ **DATE** _____ Revised 5/12/09