

MEDICAL HISTORY FORM – PART 2

Student Name: _____ Date of Birth: _____

- 13. Have you ever had a sprain, strain, or swelling after injury? Yes ___ No ___
- Have you broken or fractured any bones or dislocated any joints? Yes ___ No ___
- Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? Yes ___ No ___

If yes, check the appropriate one and explain below.

- | | | |
|---------------|-------------|---------------|
| ___ Head | ___ Elbow | ___ Hip |
| ___ Neck | ___ Forearm | ___ Thigh |
| ___ Back | ___ Wrist | ___ Knee |
| ___ Chest | ___ Hand | ___ Shin/Calf |
| ___ Shoulder | ___ Finger | ___ Ankle |
| ___ Upper Arm | ___ | ___ Foot |

- 14. Do you want to weigh more or less than you do now? Yes ___ No ___
- Do you lose weight regularly to meet weight requirements for your sport? Yes ___ No ___
- 15. Do you feel stressed out? Yes ___ No ___
- 16. Record the dates of your most recent immunizations (shots) or disease for:

Tetanus _____ Measles _____
 Hepatitis B _____ Chickenpox _____

17. Are you currently under a doctor's care?

FOR FEMALES ONLY:

- 18. When was your first menstrual period? _____
- What was your most recent menstrual period? _____
- How much time do you usually have from the start of one period to the start of another? _____
- How many periods have you had in the last year? _____
- What was the longest time between periods in the last year? _____

Explain "Yes" answers here:

Please list all prescribed medication taken by your child:

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

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

I have reviewed and acknowledge the information in this Medical History Form.

Physician's or Authorized Examiner's Signature: _____ Date: _____