Bow High School - Athletic Training

Initial Health History

-For NEW /FIRST-TIME ATHLETES to Bow High School Athletics
-To be completed by PARENT/GUARDIAN ALONG WITH ATHLETE
-COMPLETE NO MORE THAN 2 WEEKS PRIOR TO FIRST PRACTICE

BLUE

Sport You Are Trying Out For:

____

Name:____ Gender: ☐ Male ☐ Female Grade:_________ DOB:_____/_____/ _____

Home Address :________________________________ Home Phone:______________ Parent Email: __________________________

Primary Medical Contact:

Name:____ Relationship:____

Phone # (Daytime):_____________________ Phone # (Evening):__________________ Phone # (cellular):______________________

Personal Physician:____ Phone #:___________________________

2nd Emergency Contact: Name ____ Phone# ______________________________

Circle

EXPLAIN ANY "YES" ANSWERS ON BACK

Yes No 1. Has a doctor ever denied or restricted your participation in sports for any reason?
Yes No 2. Do you have any ongoing medical conditions (like diabetes or asthma) or see a physician regularly for any particular problem?
Yes No 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines, herbs, or nutritional supplements?
Yes No 4. Do you have allergies to medicines, pollens, foods, or stinging insects?
Yes No 5. Have you ever passed or nearly passed out **DURING** exercise?
Yes No 6. Have you ever passed or nearly passed out **AFTER** exercise?
Yes No 7. Have you ever had discomfort, pain, pressure in your chest during activity?
Yes No 8. Does your heart race or skip beats during exercise?
Yes No 9. Have you ever had any episodes of shortness of breath, palpitation, history of rheumatic fever, or unusual fatigue?
Yes No 10. Has a doctor ever told you that have (circle all that apply):
High blood pressure A heart murmur
High cholesterol A heart infection
Yes No 11. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)
Yes No 12. Has anyone in your family died for no apparent reason?
Yes No 13. Does anyone in your family have a heart problem?
Yes No 14. Is there a history of young people in your family who have had congenital or other heart disease (cardiomyopathy, abnormal heart rhythms, or long QT syndrome)?
Yes No 15. Has any member or relative died of heart problem or of sudden death before age 50?
Yes No 16. Does anyone in your family have Marfan's syndrome?
Yes No 17. Have you ever spent the night in a hospital?
Yes No 18. Have you ever had surgery?
Yes No 19. Have you ever had a stress fracture?
Yes No 20. Have you ever been told that you have or have you had an x-ray for atlantoaxial (neck) instability?
Yes No 21. Do you regularly use a brace or assistive device?
Yes No 22. Were you born without or are you missing any paired organ (kidneys, eyes, ears, testicles, ovaries, etc.)?
Yes No 23. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?
Yes No 24. Do you have any rashes, pressure sores, or other skin problems?
Yes No 25. Have you had a herpes skin infection?
Yes No 26. 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)*
Yes No 27. Have you ever had any broken/fractured bones or dislocated joints? *(If yes, circle below)*
Yes No 28. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, bracing, casting or crutches? *(If yes, circle below)*

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Finger	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Lower Leg	Ankle	Foot/ Toes

Yes No 29. Has a doctor ever told you that you have asthma or allergies?
Yes No 30. Do you cough, wheeze, or have difficulty breathing during or after exercise?
Yes No 31. It there anyone in your family who has asthma?
Yes No 32. Have you ever used an inhaler or taken asthma medicine?
Yes No 33. Have you had infectious mononucleosis (mono) within the last 3 months?
Yes No 34. Have you ever had a head injury or concussion?
Yes No 35. Have you ever been hit in the head and been confused or lost your memory?
Yes No 36. Have you ever had a seizure?
Yes No 37. Do you have headaches with exercise?
Yes No 38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
Yes No 39. Have you ever been unable to more your arms or legs after bring hit or falling?
Yes No 40. When exercising in heat, do you have severe muscle cramps or become ill?
Yes No 41. Have you ever suffered a heat related illness (heat stroke)?
Yes No 42. Have you had any problems with your eyes or vision?
Yes No 43. Do you wear glasses or contacts?
Yes No 44. Do you wear protective eyewear, such as goggles or a face Shield (other than required by your sport's rules)?
Yes No 45. Are you unhappy with your current weight?
Yes No 46. Are you trying to gain or lose weight?
Yes No 47. Has anyone recommended that you change your weight or eating habits?
Yes No 48. Any other current medical issues or concerns?

FEMALES ONLY
When was your first menstrual period?_____________________
When was you most recent menstrual period?________________
How many periods have you had in the last year?_____________

(Explain any YES answers on back)

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I have reviewed the policies listed in the athletics handbook.

Signature of Athlete________________________ Signature of Parent/Guardian________________________________ Date_______________

Updated 12/2011