PROEX
Physical Therapy

Arlington High School
Medical History Questionnaire

Athlete Information

Name ________________ DOB ________ Sex M F Class of ____

Sports Fall ____________ Winter ____________ Spring ____________

Emergency Contact Information

Parent/Guardian ________________ Phone # ____________ Cell # ____________

Parent/Guardian ________________ Phone # ____________ Cell # ____________

Insurance Information

Name of Insurance Co. ________________ Plan type HMO PPO Other

Pediatrician ________________ Phone # ____________

Answer all of the following questions to the best of your knowledge. Please explain all "YES" answers.

YES____ NO____ 1 Have you had a medical illness or injury since your last checkup or sports physical?
Explain: ____________

YES____ NO____ 2 Do you have a chronic or ongoing illness?
Explain: ____________

YES____ NO____ 3 Have you ever been hospitalized overnight?
Explain: ____________

YES____ NO____ 4 Have you ever had surgery?
Explain: ____________

YES____ NO____ 5 Do you have any allergies (i.e. pollen, medicine, food, insect bites)?
Explain: ____________

YES____ NO____ 6 Have you ever had a rash or hives during or after exercise?
Explain: ____________

YES____ NO____ 7 Are you currently taking any prescription or nonprescription medications?
Explain: ____________

YES____ NO____ 8 Have you ever taken any supplements or vitamins to help you gain or lose weight to improve performance?
Explain: ____________

YES____ NO____ 9 Have you ever passed out or been dizzy during or after exercise?
Explain: ____________

YES____ NO____ 10 Have you ever had chest pain during or after exercise?
Explain: ____________

YES____ NO____ 11 Have you ever had racing of the heart/skipped heartbeats, or a heart murmur?
Explain: ____________

YES____ NO____ 12 Have you ever had high blood pressure or high cholesterol?
Explain: ____________

YES____ NO____ 13 Has any family member or relative died of heart problems or of sudden death before the age of 50?
Explain: ____________

YES____ NO____ 14 Have you had a severe viral infection (i.e. myocarditis, mononucleosis, etc.) within the past year?
Explain: ____________

YES____ NO____ 15 Has a physician ever denied or restricted your participation in sports for any heart problems?
Explain: ____________

YES____ NO____ 16 Have you ever become ill from exercising in the heat, experienced heat cramps, or heat exhaustion?
Explain: ____________

YES____ NO____ 17 Do you cough, wheeze, or have trouble breathing during or after exercise?
Explain: ____________

YES____ NO____ 18 Do you have asthma? If so do you use an inhaler?
Explain: ______________________________

YES____ NO____ 19 Have you ever been informed that you have epilepsy or any abnormality of the circulatory system or brain?
Explain: ______________________________

YES____ NO____ 20 Have you ever experienced a seizure or convulsions?
Explain: ______________________________

YES____ NO____ 21 Do you have diabetes? If so What type and do you wear a pump or take insulin injections?
Explain: ______________________________

YES____ NO____ 22 Have you ever had a head injury or concussion? (please supply date(s) of injury)
Explain: ______________________________

YES____ NO____ 23 Have you ever been knocked out, lost consciousness, or lost your memory? (please supply times and dates)
Explain: ______________________________

YES____ NO____ 24 Do you have frequent or severe headaches?
Explain: ______________________________

YES____ NO____ 25 Have you had numbness or tingling in your arms, hands, legs, or feet?
Explain: ______________________________

YES____ NO____ 26 Have you ever had a stinger, burner, or pinched nerve?
Explain: ______________________________

YES____ NO____ 27 Have you had any injury to the neck involving nerves, vertebrae, or discs that incapacitated you for a week or more?
Explain: ______________________________

YES____ NO____ 28 Have you fractured, dislocated sprained or strained any of the following areas? If yes, please explain:

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

Explain: ______________________________

YES____ NO____ 29 Have you ever been advised to have surgery to correct a shoulder, hip, knee or ankle condition? If so, what was the injury and surgery date?
Explain: ______________________________

YES____ NO____ 30 Do you have a pin, screw, or plate somewhere in your body as a result of bone or joint surgery?
Explain: ______________________________

YES____ NO____ 31 Have you ever had a bone graft or spinal fusion?
Explain: ______________________________

YES____ NO____ 32 Have you ever had any problems with you eyes or vision? If so do you wear glasses, contacts or protective eye gear?
Explain: ______________________________

YES____ NO____ 33 Do you wear any dental appliances? If yes, please list.
Explain: ______________________________

YES____ NO____ 34 Do you have any dead teeth? If yes, please indicate approximate location.
Explain: ______________________________

YES____ NO____ 35 Have you ever had any problems with your hearing? If so do you wear a hearing device?
Explain: ______________________________

Release to Treat:

By signing below, I hearby authorize the Athletic Training Staff, Team Physicians, School Nurses, Medical Consultants and Athletic Staff to have access to information and to provide any and all care deemed necessary for any specific injury or condition and to release any medical or insurance information necessary. By signing below, I hearby authorize the above parties to release and share any necessary information needed to treat a specific injury or condition, whether pre-exisiting or acute.

Student Signature ______________________________ Date ____________

Parent Signature ______________________________ Date ____________

Please return to Kristen Lane, MS, MSED, ATC prior to the high school athletic season.