HARRIS-STOWE STATE UNIVERSITY **Health History Form**

Student ID#_____

Student_____Birthdate ____/____/____
Last First Middle

Sex: ____F____M Age_____ Home Phone_____ Student Cell Phone #_____

Address _____
Street City State Zip

Instructions: All questions must be answered. Any further health problems must be discussed with your personal physician or physician administering this exam. This screening physical examination is a confidential document.

	Medical History: Please explain YES answers in detail.	YES	NO	Please explain YES answers below.
1.	Have you had a medical illness or injury since your last athletic or regular check-up?			
2.	Do you have an ongoing or chronic illness?			
3.	Have you ever had surgery or been advised to have surgery?			
4.	Are you currently taking any prescription or nonprescription (over-the-counter) medications, pills, or inhaler?			
5.	Have you ever taken any supplements or vitamins to help you gain or lose weight or to improve your performance (i.e. Creatine, Multivitamins)?			
6.	Do you have any allergies (i.e. pollen, medicine, food, or stinging insects)?			
7.	Have you ever had any skin problems (i.e. rash, hives, ringworm, MRSA)?			
8.	Have you ever passed out during exercise?			
9.	Have you ever been dizzy during or after exercise?			
10.	Have you ever had chest pain during or after exercise?			
11.	Have you ever had racing of your heart or skipped heartbeats?			
12.	Have you had high blood pressure or high cholesterol?			
13.	Have you ever been told that you have a heart murmur?			
14.	Has any family member or relative died of heart problems or of sudden death before the age of 50?			
15.	Have you ever had a severe viral infection (i.e. myocarditis or mononucleosis) within the past six months?			
16.	Has a physician ever denied or restricted your participation in sports for any reason?			
17.	Have you ever had a head injury or concussion?			
18.	Have you ever been knocked out, become unconscious, or suffered memory loss?			
19.	Have you ever had a seizure?			
20.	Do you have frequent or severe headaches?			
21.	Have you ever had numbness or tingling in your arms, hands, legs, or feet?			
22.	Have you ever had a stinger, burner, or pinched nerve?			
23.	Have you ever become ill from exercising in the heat?			
24.	Do you cough, wheeze, or have trouble breathing during or after activity?			
25.	Do you have asthma?			
26.	Do you have seasonal allergies?			
27.	Have you ever had ear problems?			
28.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (i.e. knee brace, orthotics, retainer, hearing aid)?			
29.	Have you ever had any problems with your eyes or vision?			
30.	Do you wear glasses, contacts, or protective eyewear?			
31.	Have you ever broken or fractured any bones or dislocated any joints?			
32.	Have you had any problems with pain or swelling in muscles, tendons, bones, or joints? If you answered yes to questions 30-31, circle the appropriate areas and explain below:			
33.	Do you smoke or use smokeless tobacco?			
34.	Have you ever used illegal substances such as marijuana, cocaine, LSD, ecstasy or other illegal substances?			
35.	Do you lose weight regularly to meet weight requirements for your sport?			

	Medical History: Please explain YES answers in detail.	

	YES		YES		YES		YES
Asthma		Dizziness/ Fainting		Gall Bladder Disorder		Mood Swings	
Back Problems		Ear Problems		Encephalitis		Muscle Bone Problems	
Blood Disorders		….Do you require signing?		Gum Disease		Nasal Problems	
Blood Pressure High		Epilepsy		German Measles		Migraine	
Blood Pressure Low		Eye disorder, Infection		Hay Fever		Mumps	
Chest Pain/Pressure		Eating Disorder		Headache (Recurrent)		Palpitations	
Chronic Cough		Arthritis		Heart Disease		Pneumonia	
Dental Disorder		Anemia		Hepatitis		Rheumatic Fevers	
Depression		Appendicitis		HIV Infection		Rupture Hernia	
Diabetes		Bloody Urine		Jaundice		Scarlet Fever	
Dysmenorrhea Cramps		Chickenpox		Kidney Disorder		Sexually Transmitted Disease	
Irregular/excessive Flow		Chronic Cough		Malaria		Substance Abuse	
Anxiety		Seizures		Mental Illness		Sleep Disturbance	
Alcohol Abuse		Diabetes		Mononucleosis		Stomach Disorder	
Surgery		Throat Problems		Tumor/Cancer/Cyst		Weakness/Paralysis	
Tuberculosis		Whooping Cough		Sickle Cell Trait		Other Disorders: List Below	

Please explain YES answers in detail below.

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

Signature_____Date_____