STUDENT MEDICAL HISTORY

Please complete the medical history form prior to your physical exam.

Student's name (print): ____ Sex _______ Age __________
Date of Birth _____________________ Phone _____________________ Grade __________

Medication – Please list all prescription and over-the-counter medications you routinely take:

Allergies
Do you have any of the following allergies? ___ Medicines ____ Pollens ____ Food ____ Stinging Insects
Is your child at risk of anaphylaxis? ____ Yes ____ No Do you have an EpiPen? ____ Yes ____No
An "Emergency Action Plan" must be uploaded in Magnus Health if your student is at risk for anaphylaxis.
Please describe your child's allergy history and symptoms:

GENERAL QUESTIONS	YES	NO
1. Has a doctor ever denied or restricted your participation in sports or physical education for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ___ Asthma ___ Diabetes ___Seizure Disorder Other: ____________________		
HEART HEALTH QUESTIONS	**YES**	**NO**
3. Have you ever passed out or nearly passed out during or after exercise?		
4. Have you ever had chest pain during or after physical activity?		
Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High Cholesterol ☐ A hear Infection ☐ Kawasaki Disease ☐ Heart Abnormality		
6. Have you ever had high blood pressure, high cholesterol, Kawasaki disease, heart murmur or heart infection?		
Has a doctor ever ordered a test for your heart?		
NEUROLOGICAL QUESTIONS		
Have you ever had a head injury or concussion? If YES, how many? When was your last concussion?		
Have you ever had a seizure? _____ Do you have frequent or severe headache?		
BONE AND JOINT QUESTIONS		
Have you ever been required to have an orthopedic surgery?		
Have you ever had a stress fracture?		
Have you had broken or fractured bones, or dislocated joints?		
Have you ever had an x-ray for neck instability?		
Do you have a history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	YES	NO
Do you cough, wheeze, or have breathing difficulty after exercise?		
Have you ever used an inhaler or taken asthma medication?		
Have you ever been diagnosed with anemia?		
Have you had mono within the last month?		
Do you or anyone in your family have sickle cell trait or disease?		
Have you ever been diagnosed with anemia?		
Do you have any problems with your eyes?		
Do you wear contact lens or glasses?		
Do you wear a hearing aid?		
Have you ever had herpes or MRSA skin infections?		
Have you ever become ill while exercising in the heat?		
Do you get frequent muscle cramps when exercising?		
Are you on a special diet, or do you avoid certain foods?		
Have you ever had an eating disorder?		
Are you concerned about needing to lose or gain weight?		
GENETIOURINARY QUESTIONS	**YES**	**NO**
Do you have a history of kidney disease?		
FEMALES ONLY:		
When was your first menstrual period?		
Do you have dysmenorrhea (painful cramping)?		
MALES ONLY:		
Do you have two testicles?		
Have you ever had testicular swelling or masses?		

Explain "Yes" answers here:

To the best of my knowledge, my answers to the above questions are complete and accurate. I agree to notify the school if illness or injury occur that may impact my student's participation. PARENT SIGNATURE AND DATE REQUIRED

Date: _______________ Parent Signature: ____