

WETHERSFIELD HIGH SCHOOL ATHLETICS PRE-SEASON MEDICAL HISTORY SCREEN

This form must be completed by a parent/guardian and is used by the athletic trainer to properly care for your student athletes in order to prevent, manage, and rehabilitate any athletic injury.

NAME: _____ **BIRTHDATE** _____ **SPORT** _____

PRIMARY CARE PHYSICIAN NAME AND NUMBER _____

DENTIST NAME AND NUMBER _____

<i>MEDICAL HISTORY: ANY OF THE FOLLOWING?</i>	<i>YES</i>	<i>NO</i>
Passing out – during or after exercise		
Dizziness – during or after exercise		
Seizures/epilepsy		
Heat Illness		
Diabetes		
Anemia or Hemophillia		
Hernia		
Congenital condition or surgery to remove an organ		
Infectious Mononucleosis (in past 6 months)		
Eating Disorders		
Substance Abuse (tobacco, alcohol, drugs, steroids)		
High/Low Blood Pressure		
Hearing/vision deficits (glasses or contacts)		
Asthma (inhaler or no)		
<i>ORTHOPEDIC HISTORY: ANY OF THE FOLLOWING?</i>	<i>YES</i>	<i>NO</i>
Current low back pain		
Elbow sprain/dislocation		
Fractured bones (with or without surgery)		
Knee ligaments/cartilage injury		
Shoulder dislocation		
Recent surgery		
Internal hardware (pins, screws, plates)		
Concussion/head injury (include most recent and total number)		
<i>CARDIAC HISTORY: ANY HISTORY OF THE FOLLOWING</i>	<i>YES</i>	<i>NO</i>
Has a doctor ever told you that you have a heart problem?		
Has a doctor ever told you that you should not exercise because of your heart?		
Have you ever experienced heart palpitations during or after exercise?		
Has a doctor ever told you that you have a heart murmur?		
Has a doctor ever told you that you have an irregular heart beat?		
Have you ever had chest pain or pressure during or after exercise?		
Have you ever fainted during exercise?		
<i>PLEASE EXPLAIN ALL "YES" ANSWERS BELOW AND ON THE BACK IF NECESSARY</i>		

Signature of athlete _____ Name of parent _____

Parent work phone _____ Parent cell phone _____

Home phone _____