GRACE COLLEGE

Health History and Physical Exam

The health history portion of this form is to be filled out by the student prior to examination by physician. This form covers all students including athletes.

Name: _____ Gender: M F Date of Birth: _____/_____/_____

Student ID # : _____ **Please answer the questions below, if unsure of the answer circle the number.**

Current medications, vitamins or supplements: _____

Medication Allergy: Y N _____ Insect or Bee allergy: Y N Food allergy: Y N _____

Other allergies: _____

General Questions	**Yes**	**No**	**Medical Questions**	**Yes**	**No**
1. Has a doctor ever denied your participation in sports for any reason?			25. Do you have any ongoing medical conditions?		
2. Have you ever spent the night in the hospital?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
3. Have you ever had surgery?			27. Have you ever used an inhaler or asthma medication?		
Heart Health Questions	**Yes**	**No**	28. Is there anyone in your family who has asthma?		
4. Have you ever passed out or nearly passed out from exercise?			29. Are you missing any body parts or internal organs?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest?			30. Do you have any groin pain or a painful bulge or hernia in your groin?		
6. Does your heart ever race or skip beats (irregular rate) during exercise?			31. Have you had infectious mononucleosis (mono) in the last month?		
7. Has a doctor ever told you that you have any heart problems?			32. Do you, or any in your family, have sickle cell trait or disease?		
8. Has a doctor ever ordered a test for your heart?			33. Do you have a history of seizures?		
9. Do you get light headed or feel more short of breath than you would expect during exercise?			34. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Have you ever had an unexplained seizure?			35. Have you ever had a concussion?		
11. Do you get more tired or short of breath more quickly than your peers?			36. Do you get frequent muscle cramps or headaches while exercising?		
12. Has any family member died of heart problems or had an unexpected sudden death before age 50?			37. Have you ever become ill while exercising in the heat?		
13. Does anyone in your family have Hypertrophic Cardiomyopathy (HCM) or Marfan Syndrome?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? Or been unable to move your arms and legs.		
14. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			39. Do you have any rashes, pressure sores, or other skin problems, or had a herpes or MRSA skin infection in the past?		
15. Has anyone in your family had unexplained fainting, seizures or near drowning?			40. Do you have any problems with your ears or hearing?		
Bone and Joint Questions	**Yes**	**No**	41. Do you wear glasses or contacts?		
16. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss practice, a game, or activities?			42. Have you had any problems with your eyes or vision, or had an eye injury?		
17. Have you ever had any broken or fractured bones or dislocated joints?			43. Do you have any concerns about your weight or follow special diets?		
18. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			44. Have you ever had an eating disorder?		
19. Have you ever had a stress fracture?			45. Have you had any dental injuries?		
20. Have you ever been told that you have neck instability or atlantoaxial instability? (Down Syndrome or Dwarfism)			46. Do you have loose dental appliances (retainers, bridge, etc.)?		
21. Do you regularly use a brace, orthotics, or other assistive devices?			47. Females: Do you have any problems with your menstrual cycles?		
22. Do you have a bone, muscle, or joint injury that is bothering you?			**If you answered yes to any questions, please write the number and explain below:**		
23. Do any of your joints become painful, swollen, feel warm, or look red?			_____		
24. Do you have any history of juvenile arthritis or connective tissue disease?			_____		
			_____		

By signing this form, I am stating that my answers are complete and correct to the best of my knowledge.

Student Signature _____ **Date** _____