

MEDICAL HISTORY FORM

Date: _____

Participant's Name: _____

Sex: _____ Age: _____ Date of Birth: _____

Social Security Number: _____ - _____ - _____

Physician's Name: _____ Physician's Phone: _____

Physician's Address: _____

In case of an emergency, which hospital do you prefer? _____

Explain any "Yes" answers at end of form:

1. Have you ever been hospitalized? Yes___ No___
2. Have you ever had surgery? Yes___ No___
3. Are you presently taking any medications or pills? Yes___ No___
4. Are you allergic to any animals? Yes___ No___
5. Are you allergic to foods? Yes___ No___
6. Are you allergic to any medicines or drugs? Yes___ No___
7. Are you allergic to any plants or pollen? Yes___ No___
8. Are you allergic to any insect stings? Yes___ No___
9. Have you ever passed out during or after exercise? Yes___ No___
10. Have you ever been dizzy during or after exercise? Yes___ No___
11. Have you ever had chest pain during or after exercise? Yes___ No___
12. Do you tire quickly during exercise? Yes___ No___
13. Have you ever had high blood pressure? Yes___ No___
14. Have you ever been told you have a heart murmur? Yes___ No___
15. Have you ever had racing of your heart or skipped heartbeats? Yes___ No___
16. Has anyone in your family died of heart problems? Yes___ No___
17. Has anyone in your family had a sudden death before age 50? Yes___ No___
18. Do you have any skin problems (itching, rashes, etc...)? Yes___ No___
19. Have you ever had a head injury? Yes___ No___
20. Have you ever been knocked out or unconscious? Yes___ No___
21. Have you ever had a seizure? Yes___ No___

(OVER)

22. Have you ever had a pinched nerve? Yes___ No___
23. Have you ever had heat or muscle cramps? Yes___ No___
24. Have you ever been dizzy or passed out in the heat? Yes___ No___
25. Do you have trouble breathing? Yes___ No___
26. Do you cough during or after activity? Yes___ No___
27. Do you use any special equipment (pads, braces, etc...)? Yes___ No___
28. Have you ever had problems with your eyes or vision? Yes___ No___
29. Do you wear glasses or contacts or protective eyewear? Yes___ No___
30. Have you ever sprained/strained, dislocated, broken, fractured, had repeated swelling, or other injury to any bones or joints?Yes___ No___
31. Have you had any other medical problem (diabetes, etc...)? Yes___ No___
32. When was your last tetanus shot? _____
33. When was your last measles shot? _____
34. Is there any other condition that we should be aware of in case of an emergency or to prevent any injury from occurring while you participate with the Olivette Parks and Recreation Department?

35. Please explain any "yes" answers: