SWHS Athletic Trainer Medical History Form

MEDICAL HISTORY: Any history of the following?	YES	NO
Dizziness (during or after exercise)		
Seizures/Epilepsy		
Heat Illness		
Diabetes		
Sickle Cell		
Anemia/Hemophilia		
Hernia		
Congenital Condition or Surgery to remove an organ		
Infectious Mononucleosis (in the past 6 months)		
Eating Disorders		
High/Low Blood Pressure		
Heart Murmur		
Heart Palpitations or Irregular Heartbeat		
Hearing/Vision Defects (glasses or contacts)		
Asthma		
Allergies		
Current Medications		
If you answered yes to any of the above please explain:		
ORTHOPEDIC HISTORY: Any history of the following?		
Current low back pain		
Upper extremity Sprain/Strain/Dislocation		
Lower Extremity Sprain/Strain/Dislocation		
Fractured or Broken Bones		
Internal Hardware (pins or screws or plates)		
Concussion/Head Injury		
Other:		
If you answered yes to any of the above please explain:		

Athlete's Name: _____ Birth date: _____

Fall/Winter/Spring Sport(s): _____

Primary Care Physician: _____ Office Phone: _____

Parent/Guardian 1: _____

Work Phone: _____ Home Phone _____ Cell Phone _____

Parent/Guardian 2: _____

Work Phone: _____ Home Phone _____ Cell Phone _____

_____ _____

Signature of Athlete Signature of Parent