ALVIN COMMUNITY COLLEGE
Student-Athlete Health History Questionnaire Form

The information contained in this medical history form will only be used by the Athletic Department of Alvin Community College This information will remain CONFIDENTIAL at all times.

Part 1. Student Information (to be completed by student or parent)

Student's Name:_____ Sex:_____ Age:_____ Date of Birth:_____/_____/_____

Social Security #:_____ Sport(s):_____ Email: _____

Home Address: _____ Phone: _____

Personal Physician: _____ Office Phone: _____

In case of emergency, contact: Name: _____

Relationship to Student-Athlete: _____ Home Phone:_____ Cell Phone:_____

Part 2. Medical History(to be completed by student or parent). Explain "yes" answers below. Circle questions you don't know answers to.

	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
2. Do you have an ongoing chronic illness?	☐	☐
3. Have you been hospitalized overnight?	☐	☐
4. Have you ever had surgery?	☐	☐
5. Are you currently taking any prescription or non-prescription (OTC) medications or pills or using an inhaler?	☐	☐
6. Have you ever taken any supplements of vitamins to help you gain or lose weight or improve your performance?	☐	☐
7. Do you have any allergies (pollen, food, insect bites, etc)	☐	☐
8. Have you ever had a rash or hives develop during or after exercise?	☐	☐
9. Have you ever passed out during or after exercise?	☐	☐
10. Have you ever been dizzy during or after exercise?	☐	☐
11. Have you ever had chest pain during or after exercise?	☐	☐
12. Do you get tired more quickly than your friends do during exercise?	☐	☐
13. Have you ever had racing of your heart or skipped heartbeats?	☐	☐
14. Have you had high blood pressure or high cholesterol?	☐	☐
15. Have you ever been told you have a heart murmur?	☐	☐
16. Has any family member or relative died of heart problems or sudden death before age 50?	☐	☐
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	☐	☐
20. Have you ever had a head injury or concussion?	☐	☐
21. Have you ever been knocked out, become unconscious or lost your memory?	☐	☐
22. Have you ever had a seizure?	☐	☐
23. Do you have frequent or severe headaches?	☐	☐
24. Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐

	Yes	No
25. Have you ever had a stinger, burner, or pinched nerve?	☐	☐
26. Have you ever become ill from exercising in the heat?	☐	☐
27. Do you cough, wheeze or have trouble breathing during or after activity?	☐	☐
28. Do you have asthma?	☐	☐
29. Do you have seasonal allergies that require treatment?	☐	☐
30. Do you use any special protective or corrective equipment for your sport (knee brace, orthotics, etc.)	☐	☐
31. Have you had any problems with your eyes or vision?	☐	☐
32. Do you wear glasses, contacts or protective eyewear?	☐	☐
33. Have you ever had a sprain, strain or swelling after injury?	☐	☐
34. Have you broken any bones or dislocated any joints?	☐	☐
35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	☐	☐
If yes, check appropriate blank and explain below:		
☐ Head ☐ Elbow ☐ Hip ☐ Shoulder		
☐ Neck ☐ Forearm ☐ Thigh ☐ Finger		
☐ Back ☐ Wrist ☐ Knee ☐ Ankle/Foot		
☐ Chest ☐ Hand ☐ Shin/Calf ☐ Upper Arm		
36. Do you want to weigh more or less than you do now?	☐	☐
37. Do you feel stressed out?	☐	☐
38. When was your last tetanus shot? ____/____/___		
39. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	☐	☐

Females Only

40. When was your first menstrual period? _____
41. When was your most recent menstrual period? _____
42. How much time do you usually have from the start of one period to the start of another? _____
43. How many periods have you had in the last year? _____
44. What was the longest time between periods in the last year? _____

Explain "yes" answers here: _____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and accurate.

Signature of Athlete _____ **Date** _____

Signature of Parent/Guardian _____ **Date** _____

Family History

	Age	State of Health	Occupation	Cause of Death
Father				
Mother				
Brothers/ Sisters				
Husband/Wife Or Children				

Have any or your relatives had? (☐)

	Yes	Relationship
Asthma		
Arthritis		
Cancer		
Diabetes		
Epilepsy		
Heart Disease		
Kidney Disease		
Stomach Trouble		
Stroke		
Tuberculosis		

Personal History: Have you experienced any of the following? Please Comment on any positive answers below.

	Yes		Yes		Yes		Yes
Alcohol Abuse		Dizziness/Fainting		Hay Fever		Pneumonia	
Asthma		Ear Problems		Headache (Recurrent)		Rheumatic Fevers	
Back Problems		Hearing Loss		Heart Disease		Rupture/Hernia	
Blood Disorders		Do you require signing?		Hepatitis		Scarlet Fever	
Blood Pressure, High		Epilepsy		HIV Infection		Sexually Transmitted Disease	
Blood Pressure, Low		Eye Disorder, Infection		Jaundice		Substance Abuse	
Chest Pain/Pressure		Sight Loss?		Kidney Disorder		Sleep Disturbance	
Chronic Cough		Do you require a reader?		Malaria		Stomach Disorder	
Dental Disorder		Eating Changes (Recent)		Mental Illness		Surgery (Type/Date)	
Depression		Weight Gain		Mononucleosis		Throat Problems	
Diabetes		Weight Loss		Mood Swings		Tumor/Cancer/Cyst	
Dysmennorrhea, Cramps		Diet Restrictions?		Muscle/Bone Problems		Weakness/Paralysis?	
Excessive Flow		Gall Bladder Disorder		Nasal Problems		Do you need handicapped assistance?	
Irregular Flow		Gum Disease		Palpitations			

COMMENT SECTION: Please comment on any positive answers:_____

_____

_____

_____

Medications taken regularly, prescription or nonprescription (list):_____

_____

_____

Allergies to drugs, food, molds, etc. (list):_____

_____

_____

Have you had any illness or injury other than already noted? If so, please list:_____

_____

_____

PARENTAL CONSENT

The law requires, with certain exceptions, that parental permission be obtained for operative and therapeutic procedures on minors. The following consent form must be signed by the parent or legal guardian, so that medical or emergency procedures can be carried out promptly, reducing unnecessary delay and discomfort. I give my permission for such medical procedures as may be deemed necessary for my son/daughter.

Name of student:_____

Date:_____

Signature of parent/guardian_____

Relationship to student_____

Telephone_____Work_____