Sports Camps
Health History Form

Name: Sport: Date:

Date of Birth: Sex: M F

General			Cardiopulmonary			Abdominal/Genitourinary		
Allergies	Y	N	Chest Pain	Y	N	Any Abdominal Problems / Pain	Y	N
Previous Hospitalization	Y	N	Palpitations (racing heart beat)	Y	N	Bladder Infections/UTI	Y	N
Previous Surgery	Y	N	Heart Murmur	Y	N	Bleeding from Rectum	Y	N
Dental Problems	Y	N	Cardiac (heart) Disease	Y	N	Hernia	Y	N
Absence of Organ (eye, kidney, spleen, testicle)	Y	N	High Blood Pressure	Y	N	Injury to Spleen, Liver, Kidney	Y	N
Contacts/Glasses	Y	N	Dizziness/Lightheadedness	Y	N	Sexually Transmitted Disease	Y	N
Eating Disorder/Disordered Eating	Y	N	Fainting	Y	N	Menstrual Irregularity/Pain	Y	N
Diabetes	Y	N	Asthma or Wheezing	Y	N	Date of last Menstrual Period		
Sickle Cell Anemia/Trait	Y	N	Use Inhaler	Y	N			
Heat Illness	Y	N	Shortness of Breath	Y	N	**Neurological**		
Skin Problems	Y	N	Difficult Breathing	Y	N	Concussion	Y	N
Eye Disorder	Y	N	Previous EKG test?	Y	N	Frequent Headaches	Y	N
Kidney Disease	Y	N	Previous Stress Test?	Y	N	Head/Neck Injury	Y	N
Thyroid Disease	Y	N				Seizures/Epilepsy	Y	N
Cancer	Y	N	**Ear/Nose/ Throat**			Diagnosed or Treated for ADD/ADHD	Y	N
Chicken Pox	Y	N	Broken Nose	Y	N	Vision Changes	Y	N
Rheumatic Fever/Scarlet Fever	Y	N	Deviated Septum	Y	N			
Mononucleosis or Hepatitis	Y	N	Difficulty Breathing	Y	N	**Other**		
Special Equipment Needs	Y	N	Frequent Earache	Y	N	Diagnosed Learning Disability	Y	N
			Frequent Tonsil Infection	Y	N	Sleep Disturbances	Y	N
Orthopedic			Hearing Loss	Y	N			
Cervical (neck) Region	Y	N				**Mental Health**		
Thoracic (mid back) Region	Y	N	**Family History**			Treatment for Mental Health Issues	Y	N
Lumbar (low back) Region	Y	N	Death of Family Member Before the Age of 40?	Y	N	Have you been in counseling	Y	N
Chest/Rib	Y	N	Blood Clots or Clotting Disorder	Y	N	Have you **EVER** taken any medication for Mental Health issues	Y	N
Shoulders	Y	N	Bleeding Disorder	Y	N			
Upper Arm/Elbow	Y	N	Heart Disease	Y	N	**Medications**		
Forearms/Wrist	Y	N	High Blood Pressure	Y	N	Currently taking any prescription medication	Y	N
Hands/Fingers	Y	N	Connective Tissue Disease (Marfans, Ehlers-Danlos)	Y	N	Currently taking any over the counter medication regularly	Y	N
Foot/Toes	Y	N	Sickle Cell Anemia/Trait	Y	N	Currently on any Supplements	Y	N
Pelvis/Hip/Groin	Y	N						
Thigh	Y	N						
Knee	Y	N						
Lower Legs/Ankles	Y	N						

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In the space below: please explain all YES answers and/or give any other pertinent health information not included above:

Please list all allergies: (to include medication, food, and environmental)

Please list all current medication: (to include Birth Control Pills, Over the Counter Medication, Supplements)

Document reviewed by: Date:
