NWC ATHLETICS – MEDICAL HISTORY & PERSONAL DATA QUESTIONNAIRE

Name (Print) ______________________________ **Date of Birth** ____/____/____
(First, Middle Initial, Last)

Sport ____________________ **Class 1st 2nd 3rd 4th**

Medications: *List all prescription, over-the-counter medicines, and supplements (herbal and nutritional) that you are currently taking. Include: (name, dosage, frequency)* ______________________________

Do you have any allergies? Yes No *If yes, please identify specific allergy.*

Food ____________ **Medicines** ____________ **Pollens** **Stinging Insects** **Other** ____________

What is your reaction? ______________________________

Do you carry an Epi-Pen? Yes No

Instructions: Complete all questions honestly and thoroughly. Failure to disclose pre-existing injuries/conditions can effect athletes' eligibility. If you answer yes, also answer corresponding questions to give more detailed information. Include information for any care, event, injury, or procedure having taken place in the last 2 years.

General Medical History

Yes No 1. Has a doctor ever denied or restricted your participation in sports for any reason?
Yes No 2. Do you presently have an unrepaired hernia?
Yes No 3. Do you have an ongoing medical conditions? *If yes, What?(Asthma / Hypoglycemia / Diabetes / von Willebrand's disease / Hepatitis / Herpes)*

Yes No 11. Have you ever passed out or nearly passed out DURING or AFTE
facility, contact); *Released to participate (documentation require*
Yes No 12. Have you ever had discomfort, pain, tightness, or pressure in you
Yes No 13. Do you get lightheaded or feel more short of breath than expected
Yes No 14. Does your heart race or skip beats (irregular beats) during exerci
Yes No 15. Has a doctor ever told you that you have high blood pressure, hig murmur, or a heart infection? *If yes, Dr? (name, facility, contact); Released to participate (documentation required w/in 1 yr)*
Yes No 16. Has a doctor ever ordered a test for your heart? *If yes, What? (i.e. year); Released to participate (documentation required w/in 1 yr*
Yes No 17. Do you get more tired or short of breath more quickly than your f
Yes No 18. Has any family member or relative died of heart problems or had death before age 50 (including drowning, unexplained car acciden
Yes No 19. Does anyone in your family have heart disease, pacemaker, impla Conditions *(i.e. Hypertrophic Cardiomyopathy, Dilated Cardiomyop*

Nutritional Concerns

Yes	**No**	**43. Are you happy with your weight?**
Yes	**No**	**44. Are you trying to gain or lose weight?**
Yes	**No**	**45. Has anyone recommended you change your weight or eating habits?**
Yes	**No**	**46.**