

## STUDENT – ATHLETE HEALTH HISTORY FORM

1. **Yes No** Are you currently taking any medication(s)? If yes, please list.  
\_\_\_\_\_
  
2. **Yes No** Are you currently taking any nutritional, performance, or herbal supplement(s)?  
If yes, please list.  
\_\_\_\_\_
  
3. **Yes No** Do you have any known allergies? If yes, please indicate below.  
 \_\_\_ Medication, please list. \_\_\_\_\_  
 \_\_\_ Bees, what medication do you take? \_\_\_\_\_  
 \_\_\_ Food, please list. \_\_\_\_\_  
 \_\_\_ Seasonal, what medication do you take? \_\_\_\_\_
  
4. **Yes No** Do you have asthma? If yes, please list medication. \_\_\_\_\_
  
5. **Yes No** Have you ever experienced fainting, dizziness, headaches, or shortness of breath?  
If yes, please indicate cause(s).  
 \_\_\_ Heart related      \_\_\_ Physical Exertion      \_\_\_ Heat      \_\_\_ Dehydration  
 \_\_\_ Unknown      \_\_\_ Other, please explain. \_\_\_\_\_
  
6. **Yes No** Have you ever been diagnosed with a heart related condition? If yes, please explain.  
\_\_\_\_\_
  
7. **Yes No** Has anyone in your family ever died suddenly from a heart or lung condition?  
If yes, please specify.  
\_\_\_\_\_
  
8. **Yes No** Have you ever injured (broken/fractured/dislocated/sprained/strained) any part of your body  
requiring medical attention? If yes, please specify.  

SIDE	BODY PART	TYPE OF INJURY	MONTH / YEAR
Left / Right	_____	_____	_____
Left / Right	_____	_____	_____
Left / Right	_____	_____	_____
Left / Right	_____	_____	_____
Left / Right	_____	_____	_____
Left / Right	_____	_____	_____
  
9. **Yes No** Did any of these injuries require surgery? If yes, please specify when and where.  
\_\_\_\_\_
  
10. **Yes No** Have you ever sustained a head injury or concussion?  
If yes, please specify how many and the month / year(s) they occurred.  
\_\_\_\_\_
  
11. **Yes No** Have you ever lost consciousness or blacked out after sustaining a head injury?  
If yes, how many times and when?  
\_\_\_\_\_
  
12. **Yes No** Have you ever had a stinger/burner/numbness of the neck/shoulder region?  
If yes, please specify how many and the year(s) they occurred.  
\_\_\_\_\_
  
13. **Yes No** Do you utilize any type of assistive devices (braces / orthotics) while participating in athletics?  
If yes, please specify.  
\_\_\_\_\_
  
14. **Yes No** Have you experienced removal or loss of function of a paired organ (Kidney, Eye, Lung, Ovary,  
Testicle)? If yes, please specify organ(s) and circumstances.  
\_\_\_\_\_