

**Valley City State University
Athletic Pre-participation Health History**

A current physical examination must be completed prior to participation in athletic events at VCSU. This health history form must be turned in with that physical as a part of the athletes medical records at VCSU. Completion of this history prior to the actual physical examination will aid the physician in making a thorough examination.

Name _____ Sex _____ Date of Birth _____

Home Address _____

Sport(s) _____

Explain "Yes" answers below: (To be completed by student and parent/legal guardian)

- | | | |
|---|---|---|
| 1. Have you had a medical problem or injury since your last evaluation? | Y | N |
| 2. Have you ever been hospitalized or had surgery? | Y | N |
| 3. Are you presently taking any medication? | Y | N |
| 4. Do you have any allergies? | Y | N |
| 5. Have you ever passed out or experienced dizziness during or after exercise? | Y | N |
| 6. Have you ever had chest pain during or after exercise? | Y | N |
| 7. Have you ever had high blood pressure? | Y | N |
| 8. Have you ever been told you have a heart murmur, tachycardia or other heart condition? | Y | N |
| 9. Do you have a family history of heart problems or sudden death before the age of 50? | Y | N |
| 10. Do you have any skin problems? | Y | N |
| 11. Have you ever had a head injury or been knocked unconscious? | Y | N |
| 12. Do you experience chronic headaches? | Y | N |
| 13. Have you ever had a seizure or neurological disorder? | Y | N |
| 14. Have you ever had a stinger or other nerve injury? | Y | N |
| 15. Have you experienced heat exhaustion, muscle cramps or dizziness in the heat? | Y | N |
| 16. Have you experienced heat stroke or passed out in the heat? | Y | N |
| 17. Do you have trouble breathing or cough during or after activity? | Y | N |
| 18. Do you use any special medical equipment? | Y | N |
| 19. Have you had any problem with your eyes or vision? | Y | N |
| 20. Do you wear glasses or contacts or protective eye wear? | Y | N |
| 21. Have you had any other medical problems or concerns you wish to discuss? | Y | N |
| 22. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any the following bones or joints? <u> </u> Head <u> </u> Shoulder <u> </u> Thigh <u> </u> Neck <u> </u> Elbow <u> </u> Knee <u> </u> Chest
<u> </u> Scoliosis <u> </u> Forearm <u> </u> Shin/calf <u> </u> Back <u> </u> Wrist <u> </u> Ankle <u> </u> Hip <u> </u> Hand <u> </u> Foot | | |

Explain "Yes" answers: _____

Females Only

23. When was your first menstrual period? _____ When was your last menstrual period? _____

24. What was the longest between your periods last year? _____

Date _____ Signature of athlete _____

Date _____ Signature of parent/guardian _____