FRASSATI CATHOLIC HIGH SCHOOL
PHYSICAL: MEDICAL HISTORY FORM

Student Name: ______________________________ Date of Birth: ______________________

All Frassati Catholic Athletes and New Students are required to complete the Physical Form. The Medical History Form is part of the Physical and must be presented to the physician at the time of the Physical Examination. Explain "Yes" answers at end of form. Circle questions for which you don't know the answers.

The student, with the help of the parent or guardian, is to answer the following questions:

1) Have you had a medical illness or injury since your last check up or sports physical?........................Yes__ No __
2) Have you been hospitalized overnight in the past year?..Yes__ No __
3) Have you had surgery in the past year?..Yes__ No __
4) Are you currently taking any prescriptions or non-prescription (over the counter) medication or pills or using an inhaler?...Yes__ No __
5) Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?....................Yes__ No __
6) Have you ever passed out during or after exercise?..Yes__ No __
7) Have you ever been dizzy during or after exercise?..Yes__ No __
8) Have you ever had chest pain during or after exercise?..Yes__ No __
9) Do you get tired more quickly than your friends during exercise do?..Yes__ No __
10) Have you ever had racing of your heart or skipped heartbeats?...Yes__ No __
11) Have you ever been told you have a heart murmur?...Yes__ No __
12) Has any family member or relative died of heart problems or of sudden unexpected death
13) before age 50?...Yes__ No __
14) Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm?...Yes__ No __
15) Have you had a severe viral infection (for example, myocarditis or mononucleosis)
16) within the last month?..Yes__ No __
17) Has a physician ever denied or restricted your participation in sports for any heart problems?......Yes__ No __
18) Do you have any current skin problems
19) (for example, itching, rashes, acne, warts, fungus, or blisters)?...Yes__ No __
20) Have you ever had a head injury or concussion?..Yes__ No __
21) Have you ever been knocked out, become unconscious, or lost your memory?...............................Yes__ No __
    a. If yes, how many times? ____When was the last concussion? ____________
    b. How severe was each one? (Explain in the space provided)
    ____
    ____
    ____
22) Have you ever had a seizure?..Yes__ No __
23) Do you have frequent or severe headaches?..Yes__ No __
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?...Yes__ No __
26) Have you ever become ill from exercising in the heat?..Yes__ No __
27) Have you ever gotten unexpectedly short of breath with exercise?..Yes__ No __
28) Do you cough, wheeze, or have trouble breathing during or after activity?.......................................Yes__ No __
29) Do you have asthma?...Yes__ No __
30) Do you have seasonal allergies that require medical treatment?...Yes__ No __
31) Have you had any problems with your eyes or vision?..Yes__ No __
32) Are you missing any paired organs?..Yes__ No __
33) Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, and retainer on your teeth, hearing aid?)..Yes__ No __
34) Have you ever had a sprain, strain, or swelling after injury?...Yes__ No __

35) Have you broken or fractured any bones or dislocated any joints?..Yes__ No __
36) Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?.....Yes__ No __
  a. If yes, check the appropriate one and explain below.

___Head	___Elbow	___Hip
___Neck	___Forearm	___Thigh
___Back	___Wrist	___Knee
___Chest	___Hand	___Shin/Calf
___Shoulder	___Finger	___Ankle
___Upper Arm	___Foot	

37) Do you want to weigh more or less than you do now?..Yes__ No__
38) Do you lose weight regularly to meet weight requirements for your sport?.......................................Yes__ No__
39) Do you feel stressed out?..Yes__ No__
40) Record the dates of your most recent immunizations (shots) or disease for:
  Tetanus ____________________________ Measles __________________________
  Hepatitis B __________________________ Chickenpox ______________________
41) Are you currently under a doctor's care?..Yes__ No__

FOR FEMALES ONLY:

1) When was your first menstrual period? _________________
2) What was your most recent menstrual period? _________________
3) How much time do you usually have from the start of one period to the start of another? _________________
4) How many periods have you had in the last year? _________________
5) What was the longest time between periods in the last year? _________________

Explain "Yes" answers here:

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Please list all prescribed medication taken by your child:

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

Student Signature: ____ **Date:** __________________

Parent/Guardian Signature: ____ **Date:** __________________

Print Parent/Guardian Name: ____

I have reviewed and acknowledge the information in this Medical History Form.

Physician's or Authorized Examiner's Signature: ______________________________________ **Date:** _____