



# Athletic Participation Health Questionnaire

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Name \_\_\_\_\_ Age \_\_\_\_\_ Sport \_\_\_\_\_

Student's Social Security # \_\_\_\_\_

Parent Name(s) \_\_\_\_\_ Home Phone # \_\_\_\_\_

Primary Insurance Company \_\_\_\_\_ HMO / PPO (circle one)

The information contained in this medical history form will be used only by the Sports Medicine Department of Hope International University for the purpose of determining if you pose a health threat / risk to yourself on the athletic field. If necessary, this information will be discussed with you in detail by a HIU athletic trainer. This information will remain **confidential**.

Circle those injuries and / or illnesses that you have had or have now:

### I. Medical history

Diabetes	Y	N
Epilepsy	Y	N
Headaches	Y	N
Hepatitis	Y	N
Asthma	Y	N
Mononucleosis	Y	N
Convulsions	Y	N
Nosebleeds	Y	N
Heart problems	Y	N
Hypertension	Y	N
Bronchitis	Y	N
Blood in urine	Y	N
Concussion	Y	N
Appendicitis	Y	N
Tuberculosis	Y	N
Chest pain	Y	N
Kidney disease	Y	N

### II. Orthopedic history

Knee injuries	Y	N
Shoulder injuries	Y	N
Elbow injuries	Y	N
Hand injuries	Y	N
Rib / thorax injuries	Y	N
Back injuries	Y	N
Ankle injuries	Y	N
Foot / toe injuries	Y	N
Neck injuries	Y	N
Hip / groin injuries	Y	N
Forearm injuries	Y	N

Have you had surgery for any of these conditions?

Y    N    Body Part \_\_\_\_\_

Date \_\_\_\_\_ Doctor \_\_\_\_\_

Doctor's Phone # \_\_\_\_\_

If you answered YES to any of the above questions, please explain IN DETAIL below:



**V. Allergies**

Please check any allergies that you have below:

- Bee stings / insect bites      Please list any other allergies that you have: \_\_\_\_\_
  - Food: \_\_\_\_\_
  - Medication: \_\_\_\_\_
  - Latex
  - Grass
- 

**VI. Females ONLY!**

Have you had regular menstrual periods in the last year?      Y      N  
If not, explain \_\_\_\_\_

Do you take birth control medication?      Y      N  
Which one? \_\_\_\_\_

Do you take pain medication for cramping?      Y      N  
Which one? \_\_\_\_\_

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**VII. Please describe below any further injury information which is known to you and not required on this form:**

I, the undersigned, hereby acknowledge, affirm and represent to the best of my knowledge that all statements on pages one through three are true and accurate to the best of my knowledge and that no answers or information has been withheld. If any information and / or statements are false and / or have been omitted in reference to my past or present medical history, I fully understand that Hope International University, it's agents, servants, trustees, and employees disclaim liability, and will not be held liable for any injuries and / or illnesses not noted.

\_\_\_\_\_  
Student/Athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student/Athlete Signature

\_\_\_\_\_  
Parent or Guardian Signature (*if under 18 years of age*)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Signature