Name_____ M Number_____Today's Date_____

YES	NO	SPORTS CLEARANCE HISTORY
		Have you had a medical illness or injury since your last check-up or sports physical?
		Have you ever been hospitalized overnight?
		Have you ever had surgery?
		Are you currently taking any prescription or over the counter medications or pills or using an inhaler?
		Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?
		Do you have any allergies? (i.e. Pollen Medicine, food, or stinging insects) List:
		Have you ever had a rash or hives develop during or after exercise?
		Have you ever passed out during or after exercise?
		Have you ever been dizzy during or after exercise?
		Have you ever had chest pain during or after exercise?
		Do you get tired more quickly than your friends do during exercise?
		Have you ever had racing of your heart or skipped heartbeats?
		Have you had high blood pressure or high cholesterol?
		Have you ever been told you have a heart murmur?
		Has any family member or relative died of heart problems or of sudden death before age 50?
		Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?
		Has a physician eve denied or restricted your participation in sports for any heart problems?
		Do you have any current skin problems (for example itching, acne, warts, fungus, or blisters)?
		Have you had a head injury or concussion?
		Have you ever been knocked out, become unconscious, or lost your memory?
		Have you ever had a seizure?
		Do you have frequent or severe headaches?
		Have you ever had numbness or tingling in your arms, hands, legs, or feet?
		Have you ever had a stinger, burner, or pinched nerve?
		Have you ever become ill from exercising in the heat?
		Do you cough, wheeze or have trouble breathing during or after activity?
		Do you have asthma?
		Do you have seasonal allergies that require medical treatment?
		Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example neck roll, foot orthotics, retainer on your teeth, hearing aid?)
		Have you had any problems with your eyes or vision?
		Do you wear glasses, contacts or protective eyewear?
		Have you ever had a sprain, strain, or swelling after injury?
		Have you broken or fractured any bones or dislocated any joints?
		Have you ever had a sprain, strain, swelling in muscles, tendons, bones, or joints?
		Do you want to weigh more or less than you do now?
		Do you lose weight regularly to meet weight requirements for your sport?
		Do you feel stressed out?
		Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?
		Have you or has anyone in your family had sickle cell disease/trait or thalassemia or other blood related disorder?
		Women: Date of your first menstrual Period_____
		Date of your most recent menstrual period:_____
		Number of periods during the last 12 months_____
		Interval from the start of one period to the start of another_____
		Longest interval between periods in the last 12 months_____