

Sport(s): _____

Date of Exam: _____

West Valley College Athletic Health Screening Exam

Name: _____ Age: _____ Birthdate: _____

SS#: _____ Cell: _____

Address: _____

Health Insurance: _____ Family Doctor: _____

Father's Full Name: _____ Living: _____ Deceased: _____

Mothers Full Maiden Name: _____ Living: _____ Deceased: _____

Parent Address: _____ Parent Phone: _____

Medical History

1. Have you ever had any injuries such as: (Please check "yes" or "no" and use space below to explain details and dates as appropriate.)

| | Yes | No | | Yes | No | | Yes | No | | Yes | No |
|---------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|-----------------|--------------------------|--------------------------|
| Skull fracture | <input type="checkbox"/> | <input type="checkbox"/> | Heat Stroke/fainting | <input type="checkbox"/> | <input type="checkbox"/> | Painful Kneecap | <input type="checkbox"/> | <input type="checkbox"/> | Shinsplints | <input type="checkbox"/> | <input type="checkbox"/> |
| Concussion | <input type="checkbox"/> | <input type="checkbox"/> | Severe Dehydration | <input type="checkbox"/> | <input type="checkbox"/> | Locking or catching of a joint | <input type="checkbox"/> | <input type="checkbox"/> | Torn Cartilage | <input type="checkbox"/> | <input type="checkbox"/> |
| Neck Pain/Injury | <input type="checkbox"/> | <input type="checkbox"/> | Broken Bone or Fracture | <input type="checkbox"/> | <input type="checkbox"/> | Injury to Internal Organ | <input type="checkbox"/> | <input type="checkbox"/> | Deep Bruise | <input type="checkbox"/> | <input type="checkbox"/> |
| Arm/Finger numbness | <input type="checkbox"/> | <input type="checkbox"/> | Joint Dislocation | <input type="checkbox"/> | <input type="checkbox"/> | Leg/Foot Numbness | <input type="checkbox"/> | <input type="checkbox"/> | Tendonitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Back Pain/Injury | <input type="checkbox"/> | <input type="checkbox"/> | Muscle Strain/Pull | <input type="checkbox"/> | <input type="checkbox"/> | | | | Ligament Sprain | <input type="checkbox"/> | <input type="checkbox"/> |

Explain: _____

2. Do you have a history of any medical problems such as:

| | Yes | No | | Yes | No | | Yes | No | | Yes | No |
|-----------------------------|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|-----------|--------------------------|--------------------------|
| Asthma/Allergy | <input type="checkbox"/> | <input type="checkbox"/> | Mononucleosis | <input type="checkbox"/> | <input type="checkbox"/> | Seizures/Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Wheezing/Tightness In Chest | <input type="checkbox"/> | <input type="checkbox"/> | Yellow Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Visual or Hearing Impairment | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmurs/Palpitations | <input type="checkbox"/> | <input type="checkbox"/> | Skin Disease, Boils, Cold Sores | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Sickle cell Disease | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Easy Bruisability or Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| High or Low Blood Sugar | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | |

Explain: _____

3. Are you allergic to any medicines or environmental agents? If YES, explain. _____

4. Have you ever been hospitalized or had an operation or surgery? If YES, explain. _____

5. Females: Date of last menstrual period _____. Do you have any gynecological problems or concerns? If YES, explain. _____

6. Have you ever had X-Rays, worn a cast, splint, or sling, or used crutches? If YES, explain. _____

7. Have you recently or currently taken any sports supplements or vitamins? If YES, describe. _____

8. Do you take any medications on a regular basis? If YES, which medications and for what medical problems? _____

9. Do you have any questions about your current health or additional information to share with the doctor? Please add here. _____