

MIAA RECOMMENDED SPORTS CANDIDATE MEDICAL QUESTIONNAIRE

PART A - HISTORY

DATE OF EXAM: _____

Student's name: _____ sex: _____ Age: _____ Date of Birth: _____

Grade: _____ School _____ Sport(s): _____

Address: _____ Tel: Phone: _____

Physician: _____ Tel: Holyoke Office (413) 536-2393

Tel: South Hadley Office: (413) 532-0300

IN CASE OF AN EMERGENCY CONTACT:

Name: _____ Relationship: _____ Tel: H _____ W _____

EXPLAIN "YES" ANSWERS BELOW. CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWER TO.

YES NO YES NO

- 1. Have you had a medical illness or injury since your last checkup or sports physical?
- 2. Have you ever been hospitalized overnight? Have you ever had surgery?
- 3. Are you currently taking any prescription or nonprescription (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?
- 4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)? Have you ever had a rash or hives develop during or after exercise?
- 5. 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? Shoulder Have you ever had racing of your heart or skipped heartbeat? 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 ever denied or restricted your participation in sports for any heart problems?
- 6. Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus or blisters)?
- 7. Have you ever 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 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?
- 8. Have you ever become ill from exercising in the heat?
- 9. Do you cough, wheeze or have trouble breathing during or after activity? Do you have seasonal allergies that require medical treatment?
- 10. Do you use 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, retainer on your teeth, hearing aid)?
- 11. Have you had any problems with your eyes or vision? Do you wear glasses, contacts or protective eyewear?
- 12. Have you ever had a sprain, strain, or swelling after injury? Have you broken or fractured any bones or dislocated any joints? Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?
If yes circle the appropriate item and explain below:
Head Elbow Hip
Neck Forearm Thigh
Back Wrist Knee
Chest Hand Shin/Calf
Finger Ankle
Upper Arm Foot
- 13. Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your sport?
- 14. Do you feel stressed out?
- 15. Record the dates of your most recent immunization (shots) for:
Tetanus: _____ Measles: _____
Hepatitis B: _____ Chickenpox: _____

FEMALES ONLY:

- 16. When was your last menstrual period? _____
When was your most recent menstrual period? _____
How much time do you usually have from the start of one period to the start of another? _____
How many periods have you had last year? _____
What was the longest time between periods in the last year? _____
Explain "Yes" answers here: _____

I HEARBY STATE THAT TO THE BEST OF MY KNOWLEDGE, MY ANSWERS TO THE ABOVE QUESTIONS ARE CORRECT.

Signature _____ Signature of Parent/Guardian _____

Date: _____ Date: _____