



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 _____

Physician _____ Tel _____

IN CASE OF AN EMERGENCY, CONTACT:

Name _____ Relationship _____ Tel (H) _____ (W) _____

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

	YES	NO		YES	NO
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	29. 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, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	30. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	31. Do you wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	32. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	33. Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	34. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, check appropriate box and explain below:	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Head	Elbow	Hip
8. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Neck	Forearm	Thigh
9. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Back	Wrist	Knee
10. Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Chest	Hand	Shin/Calf
11. Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder	Finger	Ankle
12. Have you ever had racing of your heart or skipped heartbeat?	<input type="checkbox"/>	<input type="checkbox"/>	Upper Arm		Foot
13. Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	35. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	36. Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
15. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	37. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	38. Record the dates of your most recent immunizations (shots) for:		
17. Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____	Measles _____	
18. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____	Chickenpox _____	
19. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>			
20. Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>			
21. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>			
22. Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>			
23. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>			
24. Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>			
25. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>			
26. Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>			
27. Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>			
28. Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>			

Explain "Yes" answers here: _____

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

Signature of Athlete/Date _____ Signature of Parent-Guardian/Date _____