

Returning Athlete Follow-Up Health Appraisal

Name _____ **Sport** _____
Date of Birth _____ **Age** _____ **Year of Eligibility:** Fr So Jr Sr 5th
Local Home/Cell phone # _____

Since Your Last Physical:

- | 1. Has there been a change in your medical insurance coverage? | Yes | No | | | | | | | | | | | | | | | | |
|--|-----------|----------------|----------------|-----------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|--|--|
| 2. If yes, a copy of new medical card provided? | Yes | No | | | | | | | | | | | | | | | | |
| 3. Are you taking any medication?
If yes, please specify: _____ | Yes | No | | | | | | | | | | | | | | | | |
| 4. Are you taking any vitamin or health supplement, weight loss or weight gain product, steroid, or performance enhancement product? If yes, please specify: _____ | Yes | No | | | | | | | | | | | | | | | | |
| 5. Have you ever been diagnosed with asthma? | Yes | No | | | | | | | | | | | | | | | | |
| 6. Have you experienced fainting, dizziness, headaches, or shortness of breath during exercise?
If yes, please indicate causes(s):
___Heart related ___Physical Exertion ___Heat ___Dehydration ___Unknown
___Other, please explain. _____ | Yes | No | | | | | | | | | | | | | | | | |
| 7. Have you experienced chest pains or been diagnosed with a heart related condition?
If yes, please specify: _____ | Yes | No | | | | | | | | | | | | | | | | |
| 8. Has anyone in your family died suddenly before age 50 or from a heart or lung condition?
If yes, please specify: _____ | Yes | No | | | | | | | | | | | | | | | | |
| 9. Have you ever sustained a head injury or concussion?
Date of injury: _____ | Yes | No | | | | | | | | | | | | | | | | |
| 10. Have you lost consciousness or blacked out after sustaining a head injury?
If yes, how many times and when? _____ | Yes | No | | | | | | | | | | | | | | | | |
| 11. Have you started utilizing any type of assistive devices (braces/orthotics) while participating in athletics?
If yes, please specify. _____ | Yes | No | | | | | | | | | | | | | | | | |
| 12. Have you sustained an injury (broken/fractured/sprained/strained) to any part of your body requiring medical attention? If yes, please specify: | Yes | No | | | | | | | | | | | | | | | | |
| <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">SIDE</th> <th style="width: 25%;">BODY PART</th> <th style="width: 30%;">TYPE OF INJURY</th> <th style="width: 30%;">TREATMENT</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> | SIDE | BODY PART | TYPE OF INJURY | TREATMENT | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | | |
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| _____ | _____ | _____ | _____ | | | | | | | | | | | | | | | |
| _____ | _____ | _____ | _____ | | | | | | | | | | | | | | | |
| _____ | _____ | _____ | _____ | | | | | | | | | | | | | | | |
| 13. Have you had any type of surgery or loss of organ(s)?
If yes, please specify. _____ | Yes | No | | | | | | | | | | | | | | | | |
| 14. Have you developed any new health related conditions in the last year?
If yes, please specify: _____ | Yes | No | | | | | | | | | | | | | | | | |
| Females ONLY: Has there been a change in your menstrual cycle?
Date of your last menstrual period _____ | Yes | No | | | | | | | | | | | | | | | | |

***** I attest that the above medical history questions have been answered honestly and accurately. *****

Student-Athlete Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____
(REQUIRED If under 18 years of age)