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? Yes No
   If yes, please specify:_________________________________

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? Yes No
   If yes, please indicate causes(s):
   ___Heart related ___Physical Exertion ___Heat ___Dehydration ___Unknown
   _____Other, please explain. ____

7. Have you experienced chest pains with exercise or been diagnosed with a heart related condition? Yes No
   If yes, please specify.____

8. Has anyone in your family died suddenly or before age 50 or from a heart or lung condition? Yes No
   If yes, please specify: ____

9. Have you ever sustained a head injury or concussion? Yes No
   Date of injury: ____________________________________

10. Have you lost consciousness or blacked out after sustaining a head injury? Yes No
    If yes, how many times and when? ____

11. Have you started utilizing any type of assistive devices (braces/orthotics) while participating in athletics? Yes No
    If yes, please specify. ____

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

SIDE	BODY PART	TYPE OF INJURY	TREATMENT
______	_________________	____________________________	____________________
______	_________________	____________________________	____________________
______	_________________	____________________________	____________________

13. Have you had any type of surgery or loss of organ(s)? Yes No
    If yes, please specify. ____

14. Have you developed any new health related conditions in the last year? Yes No
    If yes, please specify: ____

Females ONLY: Has there been a change in your menstrual cycle? Yes No
Date of your last menstrual period ______________________

***** 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)