

### 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?<br>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?<br>If yes, please indicate causes(s):<br>___Heart related    ___Physical Exertion    ___Heat    ___Dehydration    ___Unknown<br>___Other, please explain. _____  | Yes       | No             |                |           |       |       |       |       |       |       |       |       |       |       |       |       |  |  |
| 7. Have you experienced chest pains or been diagnosed with a heart related condition?<br>If yes, please specify: _____   | Yes       | No             |                |           |       |       |       |       |       |       |       |       |       |       |       |       |  |  |
| 8. Has anyone in your family died suddenly before age 50 or from a heart or lung condition?<br>If yes, please specify: _____   | Yes       | No             |                |           |       |       |       |       |       |       |       |       |       |       |       |       |  |  |
| 9. Have you ever sustained a head injury or concussion?<br>Date of injury: _____   | Yes       | No             |                |           |       |       |       |       |       |       |       |       |       |       |       |       |  |  |
| 10. Have you lost consciousness or blacked out after sustaining a head injury?<br>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?<br>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="text-align: left; width: 15%;">SIDE</th> <th style="text-align: left; width: 25%;">BODY PART</th> <th style="text-align: left; width: 30%;">TYPE OF INJURY</th> <th style="text-align: left; 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 | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |  |  |
| SIDE   | BODY PART | TYPE OF INJURY | TREATMENT      |           |       |       |       |       |       |       |       |       |       |       |       |       |  |  |
| _____  | _____     | _____          | _____          |           |       |       |       |       |       |       |       |       |       |       |       |       |  |  |
| _____  | _____     | _____          | _____          |           |       |       |       |       |       |       |       |       |       |       |       |       |  |  |
| _____  | _____     | _____          | _____          |           |       |       |       |       |       |       |       |       |       |       |       |       |  |  |
| 13. Have you had any type of surgery or loss of organ(s)?<br>If yes, please specify. _____   | Yes       | No             |                |           |       |       |       |       |       |       |       |       |       |       |       |       |  |  |
| 14. Have you developed any new health related conditions in the last year?<br>If yes, please specify: _____  | Yes       | No             |                |           |       |       |       |       |       |       |       |       |       |       |       |       |  |  |
| <b>Females ONLY:</b> Has there been a change in your menstrual cycle?<br>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)