TRACY UNIFIED SCHOOL DISTRICT
PRE-PHYSICAL MEDICAL HISTORY FORM

DATE _____

NAME _____ **SEX** ____ **AGE** ____ **DATE OF BIRTH** _____

GRADE _____ **SPORTS: FALL** _____ **WINTER** _____ **SPRING** _____

PERSONAL PHYSICIAN _____ **ADDRESS** _____

PHYSICIAN PHONE # _____

1	Have you ever been hospitalized?	YES____	NO____
	Have you ever had surgery?	YES____	NO____
2	Are you presently taking any medications or pills?	YES____	NO____
3	Do you have any allergies (medicine, bees or other stinging insects)?	YES____	NO____
4	Have you ever passed out during or after exercise?	YES____	NO____
	Have you ever been dizzy during or after exercise?	YES____	NO____
	Have you ever had chest pain during or after exercise?	YES____	NO____
	Do you tire more quickly than your friends during exercise?	YES____	NO____
	Have you ever had high blood pressure?	YES____	NO____
	Have you ever been told that you have a heart murmur?	YES____	NO____
	Have you ever had racing of your heart or skipped hearbeats?	YES____	NO____
	Has anyone in your family died of heart problems or a sudden death before age 50?	YES____	NO____
5	Do you have any skin problems (itching, rashes, acne)?	YES____	NO____
6	Have you ever had a head injury?	YES____	NO____
	Have you ever been knocked out or unconscious?	YES____	NO____
	Have you ever had a seizure?	YES____	NO____
	Have you ever had a stinger, burner or pinched nerve?	YES____	NO____
7	Have you ever had heat or muscle cramps?	YES____	NO____
	Have you ever been dizzy or passed out in the heat?	YES____	NO____
8	Do you have trouble breathing or do you cough during or after activity?	YES____	NO____
9	Do you use any special equipment (pads, braces, neck rolls, mouth guard, etc.)?	YES____	NO____
10	Have you had any problems with your eyes or vision?	YES____	NO____
	Do you wear glasses or contacts or protective eye wear?	YES____	NO____
11	Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints	YES____	NO____

☐ Head ☐ Shoulder ☐ Thigh ☐ Neck ☐ Elbow ☐ Knee ☐ Chest

☐ Forearm ☐ Shin/calf ☐ Back ☐ Wrist ☐ Ankle ☐ Hip ☐ Hand ☐ Foot

12 Have you had any other medical problems (infectious monoculeosis, diabetes, etc)? YES____ NO____

13 Have you had a medical problem or injury since your last evaluation? YES____ NO____

14 When was your last tetanus shot? _____

When was your last measles immunization? _____

15 **For Girls only**: When was your first menstrual period? _____ last menstrual period? _____

What was your longest time between your periods last year? _____

Explain "Yes" answers:

_____

_____

_____

_____

I herby state that, to the best of my knowledge my answers to the above questions are correct.

_____ Athlete Signature

_____ Parent/Guardian Signature