**Explain “Yes” Answers here:**

1. Have you had a medical illness or injury since your last check-up or sports physical?
2. Has a doctor ever denied or restricted your participation in sports for any reason?
3. Do you have any ongoing or chronic illness like diabetes or epilepsy?
4. Are you currently taking any prescriptions (including female hormones/oral contraceptive) or non-prescription (over the counter) medications, pills?
5. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?
6. Do you have seasonal allergies that require medical treatment?
7. Do you have allergies to any medications, pollens, foods or stinging insects?
8. Have you ever developed hives with exercise?
9. Has a physician ever denied or restricted your participation in sports for any reason?
10. Have you ever passed-out or nearly passed-out during or after exercise?
11. Have you ever been dizzy during or after exercise?
12. Have you ever had chest pain during or after exercise?
13. Have you ever had racing of the heart or had your heart skip heartbeats?
14. Do you get tired more quickly than your friends do during exercise?
15. Have you ever been told that you have high blood pressure, high cholesterol, a heart murmur, or heart infection?
16. Has anyone in your family have Marfan syndrome?
17. Does anyone in your family have Marfan syndrome?
18. Have you ever been unable to move your arms or legs after being hit or falling?
19. Have you ever had a head injury or concussion?
20. Have you ever had a stinger, burner, or pinched nerve?
21. Have you ever had a severe viral infection (ex: mononucleosis) within the last month?
22. Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus, infections, or blisters)?
23. Have you ever had a stress fracture?
24. Have you ever had a sprain, strain, or tendonitis that caused you to miss a practice or competition?
25. Have you ever had a broken, chipped, or loose tooth or dental plate?
26. Have you ever had a broken, chipped, or loose tooth or dental plate?
27. Do you regularly use any braces or assistive devices (ex: knee brace, special neck roll, foot orthotics, retainer on your teeth, or hearing aid)?
28. Has a doctor ever told you that you have asthma?
29. Do you cough, wheeze, or have trouble breathing during or after activity?
30. Is there anyone in your family who has been diagnosed with asthma?
31. Have you ever used an inhaler or taken asthma medicine?
32. Were you born without, or are you missing a kidney, eye, testicle, or any other organ?
33. Have you had a severe viral infection (ex: mononucleosis) within the last month?
34. Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus, infections, or blisters)?
35. Have you ever had a head injury or concussion?
36. Have you ever been knocked-out, become unconscious or lost your memory?
37. Have you ever had a seizure?
38. Do you have frequent or severe headaches?
39. Have you ever had numbness, tingling, or weakness in your arms, hands, legs, or feet?
40. Have you ever experienced chest pain?
41. Have you ever had a stinger, burner, or pinched nerve?
42. When exercising in the heat have you ever had severe muscle cramps, fainting, or become ill?
43. Has a doctor ever told you or anyone in your family that you have sickle cell trait or sickle cell disease?
44. Have you had problems with your eyes or vision?
45. Do you wear glasses, contact, or protective eyewear (ex: goggles)?
46. Have you ever had a broken, chipped, or loose tooth or dental plate?
47. Are you satisfied with your body shape and size?
48. Are you currently trying to gain or lose weight?
49. What was your highest and lowest body weight last year?
50. When was your first menstrual period?
51. When was your most recent menstrual period?
52. How much time do you usually have from the start of one period to the start of another?
53. How many periods have you had in the last year?
54. Date of last pap/pelvic?
55. Many people feel depressed at times. Please rate any recent feelings of depression you may have had: Use a number from 0 (none) – 10 (severe)……………………………………………
56. Do you have any other concerns you would like to discuss? (e.g. social, academic, or family issues)