

NAME _____ DATE _____

**Circle questions you do not know the answers to. Explain "Yes" answers below.

**This information will be confidential between you and your doctor.

- | | | | |
|-----|---|-----|----|
| 1. | Has there been a medical illness or injury since last physical? | YES | NO |
| 2. | Are you currently taking: | | |
| | Prescription or over the counter medications? | YES | NO |
| | An inhaler? | YES | NO |
| | Supplements? Vitamins to loose or gain weight? | YES | NO |
| | Medications to improve athletic performance? | YES | NO |
| | Please list _____ | | |
| 3. | Do you want to weigh more, less or the same? | YES | NO |
| 4. | Do you have cough, wheeze, or trouble breathing during or after exercise? | YES | NO |
| 5. | During or after exercise have you ever: | | |
| | Passed out? | YES | NO |
| | Been dizzy? | YES | NO |
| | Had chest pain? | YES | NO |
| 6. | Have you ever : | | |
| | had a racing heart or skipped heart beats? | YES | NO |
| | Had high blood pressure or high cholesterol? | YES | NO |
| | Had a heart murmur? | YES | NO |
| 7. | Have you ever: | | |
| | been knocked out, become unconscious? | YES | NO |
| | Had a head injury or concussion? | YES | NO |
| | Had a seizure? | YES | NO |
| 8. | Do you have: | | |
| | numbness, tingling in arms, hands, legs, or feet? | YES | NO |
| | Frequent or severe headaches? | YES | NO |
| 9. | Have you ever: | | |
| | had problems with pain or swelling of muscles, joints? | YES | NO |
| 10. | Have you ever become ill exercising in the heat? | YES | NO |
| 11. | Are you stressed out? | YES | NO |
| 12. | Are you depressed? | YES | NO |
| 13. | Do you have any problems with peer relationships? | YES | NO |
| 14. | Do you drink alcoholic beverages? | YES | NO |
| | If so, what and how much? _____ | | |
| 15. | Do you do drugs? | YES | NO |
| | If so, what and how frequently? _____ | | |
| 16. | Do you or your friends ever carry a weapon? | YES | NO |
| 17. | Do you smoke? | YES | NO |
| 18. | Are you sexually active? Or have been? | YES | NO |
| | If yes, answer the following questions. | | |
| | Do you have more than one partner? | YES | NO |
| | What type of contraception are you using? _____ | | |
| | Do you have any questions about birth control? | YES | NO |
| | Do you have any questions about sexually transmitted diseases? | YES | NO |

Any additional information:

FEMALES ONLY:

- At what age did you have your first menstrual period? _____
- Most recent period? _____
- Any problems with period? _____
- Do you think you might be pregnant? YES NO

Updated 2011