



# JJC Wolves Medical History Questionnaire



Date \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Sport(s) \_\_\_\_\_

Personal Physician \_\_\_\_\_

	Yes	No		Yes	No
1. Have you ever fainted or passed out when exercising?	<input type="checkbox"/>	<input type="checkbox"/>	40. Has a doctor ever restricted your participation in sports?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you ever have chest tightness?	<input type="checkbox"/>	<input type="checkbox"/>	41. Do you have an ongoing medical condition?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does running ever cause chest tightness?	<input type="checkbox"/>	<input type="checkbox"/>	42. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had chest tightness, cough, or wheezing that made it difficult for you to perform in sports?	<input type="checkbox"/>	<input type="checkbox"/>	43. Are you currently taking any over-the-counter medicines, pills, vitamins or supplements?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever been treated/hospitalized for asthma?	<input type="checkbox"/>	<input type="checkbox"/>	44. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	45. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been told you have epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	46. Have you ever used an inhaler or taken asthma medications?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever been told to give up sports because of health problems?	<input type="checkbox"/>	<input type="checkbox"/>	47. Do you have any rashes, pressure sores, herpes skin infections, other skin problem?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever been told you have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	48. Has a doctor ever told you that you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever been told you have high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	49. Do you have headaches WITH exercise?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have trouble breathing or do you cough during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	50. Have you been told that you have or have you had an x/ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	51. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	52. Have you had a head injury, concussion, or ever been knocked out?	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have or have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	53. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	54. Have you had any eye or vision problems?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	55. Do you wear glasses or contacts?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever been told you have a heart arrhythmia?	<input type="checkbox"/>	<input type="checkbox"/>	56. Do you wear protective eyewear for sports?	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you have any other history of heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	57. Were you born without or are you missing a kidney, eye, testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you had a severe viral infection (eg, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	58. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever been told you had rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	59. Have you ever had numbness, tingling, or weakness in your arms or legs AFTER being hit or falling	<input type="checkbox"/>	<input type="checkbox"/>
21. Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>	60. Have you ever been unable to move your arms or legs AFTER being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
22. Are you taking any medications at the present time?	<input type="checkbox"/>	<input type="checkbox"/>	61. Has a doctor told you that you or someone in your family has sickle cell disease or trait?	<input type="checkbox"/>	<input type="checkbox"/>
23. Have you routinely taken any medication in the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	62. Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
24. Has a doctor ever ordered a test for your heart?	<input type="checkbox"/>	<input type="checkbox"/>	63. Are you trying to lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
<b>FAMILY HISTORY</b>			64. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family younger than 50 years of age:			65. Do you limit carefully what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
25. Died suddenly and unexpectedly?	<input type="checkbox"/>	<input type="checkbox"/>	66. Have you ever had a heat related injury?	<input type="checkbox"/>	<input type="checkbox"/>
26. Been treated for recurrent fainting?	<input type="checkbox"/>	<input type="checkbox"/>	67. Do you feel you take unnecessary risks?	<input type="checkbox"/>	<input type="checkbox"/>
27. Had unexplained seizure problems?	<input type="checkbox"/>	<input type="checkbox"/>	68. Do you lose (cut) weight regularly for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
28. Had unexplained drowning while swimming?	<input type="checkbox"/>	<input type="checkbox"/>	69. In the past 12 months have you received a speeding ticket?	<input type="checkbox"/>	<input type="checkbox"/>
29. Had unexplained car accident?	<input type="checkbox"/>	<input type="checkbox"/>	70. Have you ever had an injury, sprain, muscle or ligament tear, or tendonitis that caused you to miss practice or a game? If yes, mark off on page 2.	<input type="checkbox"/>	<input type="checkbox"/>
30. Had heart transplantation?	<input type="checkbox"/>	<input type="checkbox"/>	71. Have you ever had a broken bone or dislocated joint? If yes, mark off on page 2.	<input type="checkbox"/>	<input type="checkbox"/>
31. Had pacemaker or defibrillator implanted?	<input type="checkbox"/>	<input type="checkbox"/>	72. Have you had a bone or joint injury that required x/rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace or crutches? If yes, mark off below and explain on next page.		
32. Been treated for irregular heart beat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulders
33. Had heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Arms	<input type="checkbox"/> Elbows	<input type="checkbox"/> Hands/ Fingers
34. Has anyone in your family experienced sudden infant death (cot death)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Back	<input type="checkbox"/> Hips
35. Has anyone in your family been told they have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Thighs	<input type="checkbox"/> Ankles	
<b>-FEMALES ONLY-</b>			<input type="checkbox"/> Knees	<input type="checkbox"/> Feet/toes	
36. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>			
37. Are your periods regular?	<input type="checkbox"/>	<input type="checkbox"/>			
38. Are you, or have you ever been told you were anemic?	<input type="checkbox"/>	<input type="checkbox"/>			
39. Do you have, or have you ever been told you have low iron?	<input type="checkbox"/>	<input type="checkbox"/>			



**MUST FILL OUT IN FULL DETAIL**

Have you had any bone or joint injury that has required x-rays, MRI, CT, surgery, injections, physical therapy, a brace or crutches? If yes please explain what happened as well as when it occurred and how it was treated. If no, mark No.

Yes	No	Body Part	Explanation (Left or Right, Surgeries, Therapy, What month and year, What Doctor and a brief explanation)
		<u>Head</u>	
		<u>Arms</u>	
		<u>Chest</u>	
		<u>Thighs</u>	
		<u>Ankles</u>	
		<u>Neck</u>	
		<u>Elbows</u>	
		<u>Back</u>	
		<u>Knees</u>	
		<u>Feet/Toes</u>	
		<u>Shoulders</u>	
		<u>Hands/Fingers</u>	
		<u>Hips</u>	
		<u>Calves/Shins</u>	