Long Beach State Athletic Department
New Athlete Health History Record

Name: ______________________________ Sport: ______________________________
Student ID#: ____________________ Cell Phone: ______________________ Fresh ☐ Soph ☐ Jr. ☐ Sr. ☐
Current Address: ____
School Address: ____
Date of Birth: ________________ Gender: Male ☐ Female ☐
Notify in Emergency: Phone: Relationship:
Physician: Phone:
Are you covered by Insurance: Yes ☐ No ☐ Name of Insurance Company:

Instructions: Please answer each question completely and accurately. Any medical information withheld, incomplete, or incorrect relieves Long Beach State from all medical-legal liability and may disqualify you from participation on any Long Beach State Athletic team. When your reply is "yes", please give provide details related to the injury or condition (site and date of injury, treatment, medication, etc.) at the end of this questionnaire.

General Medical

	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
2. Have you ever been hospitalized overnight?	☐	☐
a. Have you ever had surgery? b. If yes, where, why?	☐	☐
3. Do you have any allergies (for example: to pollen, medicine, food, or stinging insects)? a. If yes, what?	☐	☐
4. Do you have seasonal allergies that require medical treatment?	☐	☐
5. Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
6. Have you ever become ill from exercising in the heat?	☐	☐
7. Do you cough, sneeze or have trouble breathing during or after activity?	☐	☐
8. Do you have asthma?	☐	☐
9. Are you currently taking any prescription or non prescription (over-the-counter) medications or pills or using an inhaler?	☐	☐
10. Have you had any problems with your eyes or vision?	☐	☐
11. Do you wear glasses, contacts or protective eyewear?	☐	☐
12. Have you ever had a seizure?	☐	☐
13. Do you have frequent or severe headaches?	☐	☐
14. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
15. Have you ever had a stinger, burner, or pinched nerve?	☐	☐
16. Have you ever had a head injury or concussion?	☐	☐
17. Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
18. Have you ever been tested for Sickle Cell Anemia, or Sickle Cell Trait? Results=	☐	☐
19. Have you ever had Staph Infection?	☐	☐

Cardiovascular:

	Yes	No
1. Have you ever passed out during or after exercise?	☐	☐
2. Have you ever had a rash or hives develop during or after exercise?	☐	☐
3. Have you ever had chest pain during or after exercise?	☐	☐
4. Do you get tired more quickly than your friends during exercise?	☐	☐
5. Have you ever had racing of your heart or skipped heart beats?	☐	☐
6. Have you had high blood pressure or high cholesterol?	☐	☐

7. Have you ever been told you have a heart murmur?	☐	☐
8. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
9. Have you had a severe viral infection (for example: myocarditis or mononucleosis) within the last year?	☐	☐
10. Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐

Orthopedic:

	Yes	No
1. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example: knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
2. Have you ever had a sprain, strain, or swelling of any joint or muscle after injury? If yes, check the appropriate box and explain below. ☐ Head ☐ Elbow ☐ Hip ☐ Neck ☐ Forearm ☐ Thigh ☐ Back ☐ Wrist ☐ Knee ☐ Chest ☐ Hand ☐ Shin/calf ☐ Shoulder ☐ Finger ☐ Ankle ☐ Upper arm ☐ Foot	☐	☐
3. Have you broken or fractured any bones or dislocated any joints?	☐	☐
4. Have you had any problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐
5. Do you want to weigh more or less than you do now?	☐	☐
6. Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
7. Do you feel stressed out?	☐	☐

Females Only:

1. When was your first menstrual period?	
2. When was your most recent menstrual period?	
3. How much time do you usually have from the start of one period to the start of another?	
4. How many periods have you had in the last year?	
5. What is the longest time between periods in the last year?	

Family History: Please indicate if any member of your family has suffered from any of the following illnesses:

Illness	Yes	No	Family Member	Alive/Deceased
Heart Disease				
Diabetes				
Cancer				
Stroke				

Medications: List all medications you are currently taking or have taken in past 3 months (includes inhalers and birth control)

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Supplements: List any supplements you are currently taking or have taken in the last 3 months (includes vitamins)

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I hereby certify that the medical history information given is an accurate update of my health status including past injuries and illnesses. I understand that any incorrect information may disqualify me from participation at Long Beach State and also relieves Long Beach State of all medical-legal liability.
Permission for treatment: In case of routine health examination, immunization, diagnostic procedures, treatment of illness and/or injuries, permission is hereby granted to treat the student named above at Long Beach State, and make necessary referrals to private physicians and other community facilities as indicated.

Athlete Signature:________________________________Date:________________________________

Parent/Guardian (if under 18 years old):____________________________Date:____________________