

Medical History Form

Fredericksburg Academy
10800 Academy Drive
Fredericksburg, VA 22408

Name:		Birth Date:		Gender:		Grade:	
Address:			City/Zip:				
Phone:	(H)	(W)	(M)				
Personal Physician:				Phone:			

Please fill out to the best of your ability. Explain "Yes" answers in the area provided or in the bottom area. Circle questions you are unsure or do not know.

Medications: Type/Amount/When Used	Yes	No	Head:	Yes	No
A. Prescription: _____	<input type="radio"/>	<input type="radio"/>	A. Head injury or concussion? How many?	<input type="radio"/>	<input type="radio"/>
B. Non-prescription: _____	<input type="radio"/>	<input type="radio"/>	B. Seizures? Medications: _____	<input type="radio"/>	<input type="radio"/>
C. Epi-pen: _____	<input type="radio"/>	<input type="radio"/>	C. Confused or lost memory after being hit or falling?	<input type="radio"/>	<input type="radio"/>
D. Inhaler: _____	<input type="radio"/>	<input type="radio"/>	D. Numbness or tingling in arms or legs after being hit or falling?	<input type="radio"/>	<input type="radio"/>
General Medical:			E. Headaches with exercise?	<input type="radio"/>	<input type="radio"/>
A. Doctor ever restricted or denied sport participation? Why?	<input type="radio"/>	<input type="radio"/>	F. Experience severe muscle cramps or become ill when exercising in heat?	<input type="radio"/>	<input type="radio"/>
B. Ongoing medical condition (such as asthma or diabetes):	<input type="radio"/>	<input type="radio"/>	G. Eye or vision problems?	<input type="radio"/>	<input type="radio"/>
C. Mononucleosis (mono) in the last month?	<input type="radio"/>	<input type="radio"/>	H. Wear glasses or contacts?	<input type="radio"/>	<input type="radio"/>
D. Any rashes, pressure sores, or skin conditions?	<input type="radio"/>	<input type="radio"/>	I. Wear protective eyewear, i.e. goggles?	<input type="radio"/>	<input type="radio"/>
E. Ever had herpes skin infection?	<input type="radio"/>	<input type="radio"/>	Musculoskeletal:		
F. Doctor said you or someone in your family has sickle cell trait?	<input type="radio"/>	<input type="radio"/>	A. Fractured (broken bones):	<input type="radio"/>	<input type="radio"/>
G. Trying to gain or lose weight?	<input type="radio"/>	<input type="radio"/>	_____		
H. Has it been recommended that you lose weight or change your eating habits?	<input type="radio"/>	<input type="radio"/>	B. Dislocated joints:	<input type="radio"/>	<input type="radio"/>
I. Limit or carefully control eating habits?	<input type="radio"/>	<input type="radio"/>	C. Sprains, tendinitis, muscle tears:	<input type="radio"/>	<input type="radio"/>
Allergies:			D. Stress fracture:	<input type="radio"/>	<input type="radio"/>
A. Food: _____	<input type="radio"/>	<input type="radio"/>	E. Surgery for injuries?	<input type="radio"/>	<input type="radio"/>
B. Environmental: _____	<input type="radio"/>	<input type="radio"/>	F. Atlantoaxial (neck) instability?	<input type="radio"/>	<input type="radio"/>
C. Synthetic: _____	<input type="radio"/>	<input type="radio"/>	G. Use of an assistive device or brace?	<input type="radio"/>	<input type="radio"/>
Heart:			Respiratory:		
A. Chest pain during exercise?	<input type="radio"/>	<input type="radio"/>	A. Diagnosed asthma?	<input type="radio"/>	<input type="radio"/>
B. Racing or skipping heart beats?	<input type="radio"/>	<input type="radio"/>	B. Wheeze, cough, trouble breathing during exercise?	<input type="radio"/>	<input type="radio"/>
C. High blood pressure?	<input type="radio"/>	<input type="radio"/>	C. Need to stop during 1/2 mile run?	<input type="radio"/>	<input type="radio"/>
D. Family history of high blood pressure?	<input type="radio"/>	<input type="radio"/>	D. Use inhaler or rescue breathing meds?	<input type="radio"/>	<input type="radio"/>
E. High Cholesterol?	<input type="radio"/>	<input type="radio"/>	Females Only:		
F. Heart murmur?	<input type="radio"/>	<input type="radio"/>	A. Have you ever had menstrual period?	<input type="radio"/>	<input type="radio"/>
G. Heart infection?	<input type="radio"/>	<input type="radio"/>	B. Ever missed a cycle? If yes, how long?	<input type="radio"/>	<input type="radio"/>
H. Family heart problems?	<input type="radio"/>	<input type="radio"/>	Explain "Yes" answers here:		
I. Family history of Marfan Syndrome?	<input type="radio"/>	<input type="radio"/>	_____		
J. Any family member died of heart problems before age 50?	<input type="radio"/>	<input type="radio"/>	_____		

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

Parent's Signature: _____ Date: _____