MHC

**Mandatory Health History**: (to be completed by the student)

**Name:** _____ **DOB:**_____ **Date**: _____

**Past Medical History**:

| Do you have or have you ever had/been diagnosed/been treated for: | | **Yes** | **No** |
|---|---|---|---|
| **Allergic / Immunologic** | **1. Environmental allergies**<br>● Includes pollen, animal dander, foods, **stinging insects** | | |
| | 2. Food allergies | | |
| **Autoimmune / Rheumatologic** | **3. Connective tissue disease or other autoimmune condition**<br>● **i.e. rheumatoid arthritis, lupus, ankylosing spondylitis, etc.** | | |
| | 4. Immune disorder (i.e. HIV infection, immunoglobulin deficiency) | | |
| **Blood** | **5. Anemia** | | |
| | **6. Blood clotting problems**<br>● past DVT or pulmonary embolism; known increased blood clotting<br>● **hemophilia** or insufficient blood blotting, easy bruising or bleeding | | |
| | **7. Sickle cell disease or sickle trait** | | |
| **Cardiovascular** | **8. High blood pressure** | | |
| | **9. Heart murmur** | | |
| | 10. Heart rhythm problem | | |
| | **11. Past heart infection, Past Kawasaki disease** | | |
| **Dermatologic** | 12. Acne | | |
| | 13. Eczema, or any "atopic dermatitis" requiring treatment | | |
| | **14. Past Herpes infections** | | |
| | **15. Past MRSA infections (methicillin resistant staph aureus)** | | |
| | 16. Psoriasis | | |
| **Endocrine** | **17. Diabetes:** type I or type II | | |
| | 18. Thyroid problem | | |
| **Gastrointestinal** | 19. Celiac or gluten sensitivity | | |
| | 20. Gastroesophageal reflux disease, ulcers | | |
| | 21. Inflammatory bowel disease (i.e. Crohn's or ulcerative colitis) | | |
| | 22. Irritable bowel syndrome | | |
| **Mental Health** | 23. Anxiety disorders<br>● includes panic, obsessive compulsive disorder, post-traumatic disorder | | |
| | 24. Attention deficit/hyperactivity disorder | | |
| | 25. Bipolar disorder | | |
| | 26. Depression/ dysthymia or other depressive disorder | | |
| | **27. Eating disorder** (anorexia, bulimia, binge eating disorder) | | |
| | 28. Schizophrenia | | |
| | 29. Other | | |
| | **30. Seizures** | | |
| | **31. Past head injury or concussion** | | |

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**Name:** _____ **DOB:**_____

| | | | |
|---|---|---|---|
| | 32. Migraine headaches | | |
| **Orthopedic** | **33. Broken or fractured bones, including stress fractures** | | |
| | **34. Dislocated joints** | | |
| **Respiratory** | **35. Asthma** | | |
| | **36. Chronic lung disease** (i.e. COPD, cystic fibrosis)) | | |
| **Misc.** | 37. Has infectious mononucleosis? (if yes, note when) | | |
| | **38. Were you born without or are you missing a kidney, an eye, your spleen or any other organ?** | | |
| | **39. Have you ever needed to use or been prescribed an inhaler or taken asthma medicine but don't have asthma?** | | |
| | **40. Had been diagnosed with COVID-19? (if yes, note when)** | | |
| | 41. Any other health problem not listed here? | | |

For all **"YES" responses**, please provide number and explain in the comment box provided.

**Surgical History**:

- ___none ___tonsillectomy ___hernia repair ___wisdom tooth extraction ___other (list all):

**Hospitalizations** (other than surgeries):

- ___none ___yes (list approximate dates, duration, reason):

**Allergies**

- Allergies or adverse reactions to medications: ___ none ___yes (please list med and reaction):

- Material sensitivities: ___none ___latex ___ adhesives ___ iodine ___ nickel ___other:

- Does this student have an Epi-pen? No Yes

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**Name:** _____ **DOB:**_____

**Current Medications and Doses** (attach additional sheet of paper if needed):

| Medication | Dose | Reason for taking this medication |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Are any of these medications on the NCAA list of banned substances? No Yes

2019-20 NCAA Banned Substances | NCAA.org - The Official Site of the NCAA

**If yes, and you will be playing varsity sport**(s), please download the Banned Substance Form at the MHC new student sports packet link and have your clinician complete. You will not be able to participate in varsity sports until the required documentation on banned substances is complete.

**Family Medical History**:

| Has anyone in your family been diagnosed with the following: | **Yes** | **No** |
|---|---|---|
| **1. Asthma** | | |
| **2.** Cardiovascular disease—heart attack, angina, peripheral artery disease, bypass surgery, stroke | | |
| **a. Has any family member died of heart problems or had an unexpected sudden death before age 50?** | | |
| **b. Does anyone have hypertrophic cardiomyopathy, Marfan syndrome, short QT syndrome, Frugada syndrome or ventricular tachycardia?** | | |
| **c. Does anyone have a pacemaker, implanted defibrillator or heart rhythm problems?** | | |
| **3.** Autoimmune diseases (rheumatoid arthritis, lupus, sarcoid, etc.) | | |
| **4.** Neurological disorders: migraines, seizures, Parkinson's disease, tremor | | |
| **a. Has any family member had unexplained fainting, seizures or near drowning?** | | |
| 5. Diabetes or thyroid disorder | | |
| 6. Gastrointestinal disorders (ulcers, crohn's disease, ulcerative colitis | | |
| 7. Any kind of cancer (if so, list person, cancer type below) | | |
| For all **"YES" responses**, please provide number and explain in the comment box provided. | | |

MHC

**Name:** _____ **DOB:**_____

**Sports/Physical Education/Exercise History**:

| | Yes | No |
|---|---|---|
| **1.** Has a medical professional ever denied or restricted your participation in sports for any reason? | | |
| **2.** Have you ever passed out or nearly passed out DURING or AFTER exercise? | | |
| **3.** Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | |
| **4.** Does your heart ever race or skip beats (irregular beats) during exercise? | | |
| **5.** Has a medical professional ever ordered a test for your heart? (i.e. EKG or echocardiogram) | | |
| **6.** Do you get lightheaded or feel more short of breath than expected during exercise? | | |
| **7.** Do you get more tired or short of breath more quickly than your peers do during exercise? | | |
| **8.** Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice, a game, or not exercise for more than one week? | | |
| **9.** Have you ever had an injury that required X-rays, CT scan or MRI?<br>● Or that required injections, physical therapy, brace, cast or crutches? | | |
| **10.** Have you ever been told you have neck instability?<br>● Or had an X-ray to check for neck instability? | | |
| **11.** Do you have a bone, muscle or joint injury that bothers you? | | |
| **12.** Do any of your joints become painful, red, swollen or feel warm? | | |
| **13.** Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| **14.** Do you have headaches with exercise? | | |
| **15.** Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | | |
| **16.** Have you ever been unable to move your arms or legs after being hit or falling? | | |
| **17.** Have you ever become ill while exercising in the heat? | | |
| **18.** Do you get frequency muscle cramps when exercising? | | |
| For all **"YES" responses**, please number and explain in the comment box provided below. | | |
| | | |

**Student Signature and Date**: Parent/guardian signature also required if student <18 years old.
My signature below indicates that, to the best of my knowledge, my answers to the above questions are correct.

Student: _____ Date: _____

Parent/guardian (printed name & signature):_____