

ACEL MEDICAL HISTORY EVALUATION

PART I: INFORMATION *(To be filled out by parent or guardian only)*

Name: _____ Grade: _____ School: _____
 Sex: M / F Age: _____ Date of Birth: _____ Home Telephone #: _____ Sports: _____
 Social Security Number: _____ Address: _____ City: _____ Zip: _____
 Parent's Name: _____ Parent's Employer: _____ Work Telephone #: _____
 Insurance Company: _____ Policy #: _____ Family Doctor: _____

PART II: MEDICAL HISTORY *(To be filled out by parent or guardian)*

Has or Does this athlete

Circle & please explain all "yes" answers below

- | | | |
|--|-----|----|
| 1. Have a medical problem or injury since his/her last evaluation? | YES | NO |
| Ever not been allowed to participate in sports for a medical reason? | YES | NO |
| 2. Ever been hospitalized? | YES | NO |
| Ever had surgery? | YES | NO |
| Have any missing organs? (<i>eye, kidney, testicle, etc.</i>) | YES | NO |
| 3. Presently take any medication? | YES | NO |
| 4. Have any allergies to medicine or insect bites? | YES | NO |
| 5. Passed out during or after exercise? | YES | NO |
| Been dizzy or passed out during or after exercise? | YES | NO |
| Have chest pain during or after exercise? | YES | NO |
| Tire more quickly than his/her friends during exercise? | YES | NO |
| Have high blood pressure? | YES | NO |
| Been told he/she has a heart murmur? | YES | NO |
| Have racing of the heart or skipped heartbeats? | YES | NO |
| Have a family member that died of heart problems or sudden death before age 50? | YES | NO |
| 6. Have any skin problems? | YES | NO |
| 7. Ever had a head or neck injury? | YES | NO |
| Ever been knocked out or unconscious? | YES | NO |
| Ever had a seizure? | YES | NO |
| Ever had a stinger, burner or pinched nerve? | YES | NO |
| 8. Ever had heat cramps? | YES | NO |
| Ever been dizzy or passed out in the heat? | YES | NO |
| 9. Have trouble with breathing or coughing during or after activity? | YES | NO |
| 10. Use any special equipment? (<i>pads, braces, neck rolls, eye guards, kidney belt, etc.</i>) | YES | NO |
| 11. Have any problems with vision? | YES | NO |
| Wear glasses or contacts? | YES | NO |
| 12. Ever sprained/strained, dislocated, fractured or had repeated swelling of any bones or joints? | YES | NO |
| 13. Have any medical problems listed below? (<i>Please check off</i>) | | |

_____ High Blood Pressure	_____ Rheumatic Fever	_____ Diabetes	_____ Hepatitis
_____ Mononucleosis	_____ Abnormal Bleeding	_____ Tuberculosis	_____ Asthma
_____ Sickle Cell Disease/Trait	_____ Other(<i>list</i>) _____		

14. List dates for last: Tetanus Shot: _____ Measles Immunization: _____
 15. Female athletes, list dates for: First menstrual period: _____ Last menstrual period: _____

Longest time between periods last year: _____

Please explain all "yes" answers from above: _____
