

The Connecticut State Medical Society
SPORTS CANDIDATE
HEALTH QUESTIONNAIRE

Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

Parent/Guardian: _____ Business Phone: _____

School and Grade: _____

Emergency Information:

Physician preference:

1. _____

2. _____

If neither physician is available, do we have permission to take your child to a hospital?

yes _____ no _____

Preference of hospital: _____

History:

1. Immunizations: Year of last tetanus _____ polio _____

2. Last dental visit: _____

3. Allergies: _____

4. Any medication, medicine, drugs now being taken? _____

5. Heart: Murmur? Heart Disease? Any family history of heart attacks under 50 years of age? _____

6. Do you have to stop when running a half mile? yes _____ no _____

7. Have you ever been unconscious or knocked out (concussion)? _____

8. Have you ever had problems with your eyes? _____

_____ Do you wear glasses? _____

Kidneys(urine)? _____ Hernias? _____

9. Female menstrual History: Age of onset? _____ Frequency _____ Duration _____
Problems _____
10. Major medical illnesses (e.g. seizures, anemia, diabetes, arthritis, bleeding disorders, hepatitis, mono, et

11. Overnight hospitalizations: _____
12. Operations or surgery: _____
13. Sprains, fractures or broken bones: _____
14. Ever had an x-ray of a bone or joint or had a cast, splint, cane or crutches? _____
15. Ever had an injury that caused you to miss a game or practice? _____
16. Are you being treated by a physician now? _____