Manchester University
Center for Health & Sports Medicine

HEALTH HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18)

Name (Print): _____ Date of Birth: _____

Major(s): _____ Sex assigned at birth (F, M, or intersex): _____

How do you identify your gender? (F, M, or other): _____

List past and current medical conditions: _____

_____

Have you ever had surgery? If yes, list all past surgical procedures: _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). _____

_____

Do you have any allergies: If yes, please list all your allergies (i.e., medicines, pollens, food, and/or stinging insects)

_____

_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response)				
	Not at all	**Several days**	**Over half the days**	**Nearly every day**
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Please answer No or Yes for the following questions.		
Have you ever been seen by a counselor or a psychiatrist?	**No**	**Yes**
Have you ever taken medication for mental health problems?		
Have you ever received medical care or been hospitalized for a mental health problem or an eating disorder?		
Have you ever received medical care or been hospitalized for substance abuse?		
Have you ever thought things would be better if you were dead? If yes: when?		
Have you had thoughts of harming or killing yourself? If yes: when?		

GENERAL QUESTIONS (Explain "Yes" answers at the end of the form. Circle questions if you don't know the answer?	YES (Explain your answer)	NO
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illnesses?		
HEART HEALTH QUESTIONS ABOUT YOU	YES (Explain your answer)	NO
4. Have you ever passed out or nearly passed out during or after exercise?		

5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your hear ever race, flutter in your chest or skip beats (irregular beats) during exercise:		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG).		
9. Do you get light headed or feel shorter of breath that your friends during exercise?		
10. Have you ever had a seizure:		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	YES (Explain your answer)	NO
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as Hypertrophic cardiomyopathy (HCM), Marfan syndrome, Arrhythmogenic right ventricular cardiomyopathy (ARVC), Long QT syndrome (LQTS), Short QT syndrome (SQTS), Brugada syndrome, or Catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		
BONE AND JOINT QUESTIONS	YES (Explain your answer)	NO
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	YES (Explain your answer)	NO
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashers or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?		
20. Have you had a concussion or head injury that cause confusion, prolonged headaches, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a social diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	YES(Explain your answer)	NO
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

I here by state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of student: _____ Date: _____

Signature of parent or guardian if under age of 18: _____ Date: _____