SPORTS QUESTIONNAIRE

NAME: <p.first> <p.last> DATE: <today;%10.10s>

IF YOU ANSWER YES TO ANY OF THESE QUESTIONS PLEASE EXPLAIN.

1. Is there any family history of cardiac disease or sudden death in persons under the age of 50?
YES _____ WHO _____ NO _____

2. Have you had any problem with a "racing heart: YES _____ NO _____
_____

3. Have you experienced any of the following with exercise/physical activity:
Chest Pain, Lightheadedness, Shortness of Breath YES _____ NO _____
Explanation:_____
_____

4. If you are asthmatic, have you had any significant bouts of asthma in the past year?
YES/WHEN _____ NO _____

5. Have you fainted in the last year? YES _____ NO _____
WHEN/CAUSE _____

6. Have you had significant weight loss in the past year?YES _____NO _____
_____

7. Have you suffered any injuries in the last year which resulted in a loss of consciousness or concussion? YES _____ NO _____
If yes, were you cleared? YES _____ NO _____

8. Have you had any of the following injuries in the past year:
Fracture YES _____ NO _____ Sprain YES _____ NO _____
Back Injury YES _____ NO _____ Neck Injury YES _____ NO _____
If yes, have you been cleared by Orthopedics? YES _____ NO _____

9. Are you taking any medications YES _____ NO _____
If yes, please indicate, medication and dose: _____
_____

10. Have you had any surgery? YES _____ NO _____
If yes, please indicate, what and when? _____

11. Have you ever been seen or been referred to see cardiology? YES _____ NO _____

Signature: _____ Relationship to patient: _____

updated 8/22