SPORTS QUESTIONNAIRE

NAME: _____ DATE: _____

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 tested positive for COVID-19? YES/WHEN: _____ NO _____
    Did you have a: Fever YES/# of days: _____ NO _____
    Since your recovery with COVID-19 have you had:
    CHEST PAIN or SHORTNESS OF BREATH with EXERCISE
    YES _____ NO _____

Signature: _____ Relationship to patient: _____

updated 8/22