



1200 GRANDVIEW AVENUE • DES MOINES, IOWA 50316-1599  
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**ATTENTION:**  
**THIS FORM MUST BE RETURNED PRIOR TO PARTICIPATION IN ATHLETICS**  
**MEDICAL HISTORY QUESTIONNAIRE**

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Phone number \_\_\_\_\_ Age \_\_\_\_\_ Gender  Female  Male

Personal Physician \_\_\_\_\_

- | <b>Yes</b>               | <b>No</b>                | <b>Explain any yes answers.</b>   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had surgery?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you presently under a doctor's care?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you presently taking any medications or pills?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any allergies (medicine, bees or other stinging insects)?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been dizzy during or after exercise?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had chest pain during or after exercise?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had high blood pressure?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you even been told that you have a heart murmur?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had racing of the heart or skipped heartbeats?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Has anyone in your family died of heart problems or a sudden death before the age of 50?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Has anyone in your family had Marfan's syndrome?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any skin problems (itching, rashes, acne)?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a head injury?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been knocked out or unconscious?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a seizure, "fit" or epilepsy?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a stinger, burner or pinched nerve?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had heat cramps, heat illness or muscle cramps?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have trouble breathing or do you cough during or after activity?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use any special equipment (pads, braces, eye guards, etc.)?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any problems with your eyes or vision?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wear glasses or contacts or protective eyewear?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you missing an eye, kidney, or testicle?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you every sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?<br><input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Foot<br><input type="checkbox"/> Forearm <input type="checkbox"/> Shin/calf <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> Hip <input type="checkbox"/> Hand |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any other medical problems (infectious mononucleosis, diabetes, anemia, etc.)?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a medical problem or injury since your last evaluation?  |



**MEDICAL HISTORY QUESTIONNAIRE, Page 2**

When was your last tetanus shot? \_\_\_\_\_

When was your first menstrual period? \_\_\_\_\_

When was your last menstrual period? \_\_\_\_\_

What was the longest time between your periods last year? \_\_\_\_\_

**Please explain yes answers:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby state that to the best of my knowledge, my answers to the above questions are correct.

\_\_\_\_\_  
Signature of athlete

\_\_\_\_\_  
Date