Original Date:	
Dates Revised:	

Student-athlete HEALTH HISTORY QUESTIONNAIRE

TO BE COMPLETED BY PARENT/GUARDIAN & STUDENT-ATHLETE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Last Name:	First Name:	Middle Name:	
Gender: ☐ M ☐ F	D.O.B		
Family doctor:	Date of last physical exam:		

HISTORY		
Have you had any illness/injury recently, or do you have an illness/injury now?	☐ Yes	☐ No
Have you ever been hospitalized overnight?	☐ Yes	☐ No
Do you have any chronic or recurrent illness or injury?	☐ Yes	☐ No
Have you ever had any illness lasting more than a week?	☐ Yes	☐ No
Have you had any surgery other than tonsillectomy?	☐ Yes	☐ No
Are you presently taking any medications or pills (including birth control, vitamin, aspirin, etc.)?	☐ Yes	☐ No
Have you ever passed out during exercise?	☐ Yes	☐ No
Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)?	☐ Yes	☐ No
Have you ever had chest pain or dizziness during or after exercise?	☐ Yes	☐ No
Have you ever had problems with your blood pressure or your heart?	☐ Yes	☐ No
Have any close relatives had heart problems, heart attacks or sudden death before they were age 50?	☐ Yes	☐ No
Do you have any skin problems (acne, itching, rashes, etc.)?	☐ Yes	☐ No
Have you ever had fainting, convulsions, seizures or severe dizziness?	☐ Yes	☐ No
Do you have frequent severe headaches?	☐ Yes	☐ No
Have you ever had a "stinger" or "burner" or "pinched nerve"?	☐ Yes	☐ No
Have you ever been "knocked out" or "passed out"?	☐ Yes	☐ No
Have you ever had a neck or head injury?	☐ Yes	☐ No
Have you ever had heat exhaustion, heat stroke, severe heat cramps or similar heat related problems?	☐ Yes	☐ No
Do you have asthma, trouble breathing, or cough during or after exercise?	☐ Yes	☐ No
Do you use an inhaler for asthma?	☐ Yes	☐ No
Are you diabetic?	☐ Yes	☐ No
Do you administer insulin to yourself?	☐ Yes	☐ No
Do you wear eyeglasses, contact lenses, or protective eye wear?	☐ Yes	☐ No
Have you had any problems with your eyes or vision?	☐ Yes	☐ No
Do you wear any dental appliance such as braces, bridge, plate, retainer?	☐ Yes	☐ No
Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones?	☐ Yes	☐ No
FEMALES: Have you any menstrual problems?	☐ Yes	☐ No
Have you ever torn a tendon, ligament or muscle?	☐ Yes	☐ No
Do you use special equipment (brace, etc.)?	☐ Yes	☐ No
Do you drink alcohol?	☐ Yes	☐ No
If yes, is your alcohol consumption Mild Moderate Frequent ? (circle one)		

Are you presently using tobacco in any form?	☐ Yes	☐ No
Do you have a history of sickle-cell anemia in your family?	☐ Yes	☐ No
Have you had a medical problem or injury within the last year?	☐ Yes	☐ No
Can you swim?	☐ Yes	☐ No
Do you currently use recreational or street drugs?	☐ Yes	☐ No
Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Have you any medical concerns about participating in athletic activities?	☐ Yes	☐ No
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No
Please explain any YES answer:		

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Grandmother** Maternal		
Mother			**Grandfather** Maternal		
Sibling	M F		**Grandmother** Paternal		
	M F		**Grandfather** Paternal		
	M F				
	M F		**Other: Uncle/Aunt**		
	M F				
	M F				

MEDICAL INFORMATION

Please contact the school with any updated health information. Health information will only be shared with faculty/staff on "need-to-know" basis. Health forms/information will be kept on file at the Admissions Office of the Hill Academy.

MEDICATION: All medications (except for inhalers, epi-pens, glucose tablets) will be kept locked at the school's front office and dispensed by our designated staff. **Medication will only be dispensed if the proper consent forms are completed.** Please request our Medication Administration Permission Form.

I permit my daughter/son to be assessed and treated at The Hill Academy by the school doctor/school nurse/athletic therapist, designated personnel for first aid and minor health concerns. I permit that, in case of a major medical emergency, my daughter/son will be immediately taken to York Central Hospital at 10 Trench Street, Richmond Hill.

Parent's/Guardian's Signature _____ Date _____

Parent's/Guardian's Signature _____ Date _____