Boston Public Schools

MEDICAL QUESTIONNAIRE

This form must be completed by parents and returned to the coach along with the physical examination form completed by a physician, or medical equivalent.

Student Name:	**Sex: D.O.B.: Gr.**
School:	**Coach:**

The following information is for review by the school nurse, for the purpose of optimizing safe sports participation. Please indicate Y (yes), N (no), DK (don't know).

1	Have you had a medical illness or injury since your last check up or sports physical?		19	Have you ever been knocked out, become unconscious, or lost your memory?	
2	Have you ever been hospitalized overnight?		20	Have you ever has a seizure?	
3	Have you ever had surgery?		21	Do you have frequent or sever headaches?	
4	Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?		22	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	
5	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?		23	Have you ever had a stinger, burner, or pinched nerve?	
6	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?		24	Have you ever become ill from exercising in heat?	
7	Have you ever had a rash or hives develop during or after exercise?		25	Do you cough, wheeze, or have trouble breathing during or after exercising?	
8	Have you ever passed out during or after exercise?		26	Do you have Asthma?	
9	Have you ever been dizzy during or after exercise?		27	Do you have seasonal allergies that require medical treatment?	
10	Have you ever had chest pain during or after exercise?		28	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid?	
11	Do you get tired more quickly than your friends do during exercise?		29	Have you had any problems with your eyes or vision?	
12	Have you ever had racing of your heart or skipped heartbeat?		30	Do you wear glasses, contacts, or protective eyewear?	
13	Have you had high blood pressure or high cholesterol?		31	Have you ever had a sprain, strain, or swelling after injury?	
14	Have you ever been told you have a heart murmur? If yes, please explain.		32	Have you broken or fractured any bones or dislocated any joints?	
15	Has any family member or relative died of heart problems or of sudden death before age 50?		33	Have you had any other problems with pain or swelling in muscles, tendons. Bones, or joints? If yes, circle and explain on back side of this questionnaire: Head , Elbow, Forearm, Wrist, Hand, Upper Arm, Hip, Thigh, Knee, Shin/Calf, Foot, Head, Neck, Back, or Chest?	
16	Has a physician ever denied or restricted your participation in sports for any heart problems?		34	Do you want to weigh more or less than you do now?	
17	Do you have any current skin problems (for example) itching, rashes, acne, warts, fungus, or blisters)?		36	Do you lose weight regularly to meet weight requirements for your sport?	
18	Have you ever had a head injury or concussion? How many? _____. What was the longest duration of symptoms? ____days, ____ weeks, ____ months, _____ years			Explanations of "yes: responses: (attach any documentation necessary.	

Parent Signature: _____ **Date:**_____