

Student Name: _____ DOB: _____ Grade: _____ ID: _____

MHHS Medical History Questionnaire

- | | | | | |
|--|-----------------------|-------------------|--------------------|------------------|
| 1. Have you ever been hospitalized overnight? | Yes | No | | |
| Have you ever had surgery? | Yes | No | | |
| 2. Are you currently taking medication? | Yes | No | | |
| 3. Do you have any allergies (medicines, pollen, bees)? | Yes | No | | |
| List allergies: _____ | | | | |
| 4. Have you ever passed out during exercise? (Not from heat) | Yes | No | | |
| Have you ever been dizzy during exercise? (Not from heat) | Yes | No | | |
| Have you ever had chest pain? | Yes | No | | |
| Do you tire more quickly than your friends during exercise? | Yes | No | | |
| Have you ever had high blood pressure? | Yes | No | | |
| Have you ever been told you have a heart murmur? | Yes | No | | |
| Have you ever had racing of your heart or skipped beats? | Yes | No | | |
| Has anyone in your family died of heart problems or a sudden death before the age of 40? | Yes | No | | |
| Does anyone in your family have Marfan's Syndrome? | Yes | No | | |
| 5. Do you have any skin problems (itching, rashes, breaking out)? | Yes | No | | |
| 6. Have you ever had a head injury? | Yes | No | | |
| Have you ever been "knocked out"? | Yes | No | | |
| Have you ever had a seizure? | Yes | No | | |
| Have you ever had pain from the neck to the arm? | Yes | No | | |
| 7. Have you ever had heat cramps? | Yes | No | | |
| Have you ever been dizzy or passed out in the heat? | Yes | No | | |
| 8. Do you use special pads or braces? | Yes | No | | |
| 9. Have you ever injured (broken/fractured, sprained, or dislocated): | | | | |
| ___hand/fingers | ___shoulder | ___hip | ___shin/calf | ___wrist/forearm |
| ___neck | ___thigh | ___elbow | ___chest/ribs | ___knee |
| ___ankle | ___upper arm | ___back | ___stress fracture | |
| 10. Have you ever had: | | | | |
| ___mononucleosis | ___diabetes | ___measles | ___hernia | |
| ___sickle cell trait/disease | ___headaches-frequent | ___ulcers | ___hepatitis | |
| ___asthma | ___eye/ear injuries | ___tuberculosis | | |
| 11. When was your last tetanus shot? _____ | | | | |
| 12. About your weight: do you think you are: | | | | |
| ___just right | ___too heavy/fat | ___too light/thin | | |
| 13. For Females: | | | | |
| When was your 1st period and how old were you? _____ | | | | |
| When was your last period? _____ | | | | |
| 14. Please feel free to ask the doctor to address any questions/concerns that you have _____ | | | | |

Explain all "Yes" responses to Questions 1-8:

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

Student Signature: _____ Parent Signature: _____ Date: _____

Student Name: _____ DOB: _____ Grade: _____ ID: _____

MHHS Physical Examination (To be completed by medical personnel)

Height _____ Weight _____ BP ____/____ Pulse _____

Vision (optional) _____ Left eye 20/____ Right eye 20/____

1.	Skin	
2.	Head	
3.	Eyes (PERL, EOMI, Fundi)	
4.	Ears, nose, throat	
5.	Neck	
6.	Lymphatic	
7.	Respiratory	
8.	Cardiovascular	
	Heart (murmurs?)	
9.	Abdomen	

10.	Genitalia (optional)	
11.	Extremities	
12.	Neurological	
13.	Orthopedic	
	Cervical spine/back	
	Arms/elbows/wrist/hands	
	Hips	
	Knees	
	Ankles / feet	
14.	Developmental	
	Tanner staging 1-5 (opt)	

√ = WNL X = omitted + = see "Notes" below

Please check one:

_____ Full, unrestricted clearance

_____ Not cleared. Needs clearance by specialist: (Please note below)

____ Orthopedist ____ Cardiologist ____ Other

Notes: _____

If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete. In the event that the student-athlete should be afflicted with a condition after initial clearance, the individual may require additional clearance paperwork be turned into the athletic trainer.

****Screenings may only be performed by licensed MD, DO, PAC, and NP****

****Physicals must be completed after 6/1/2026****

Athletic Screening performed by:

Print _____ MD / DO / PAC / NP (circle one)

Signature _____ Date _____

Place Practitioner Office Stamp Here (Required)