

Preseason Medical Evaluation⁰⁸

Health Questionnaire

This annual form must be completed and returned before the student athlete will be permitted to practice or play. The National Junior College Athletic Association (Article V, Section 9) and Mercer County Community College policies recommend that all student athletes have a qualifying medical evaluation "health status" review. Further medical evaluation may be required for specific matters.

Name: _____ Sport: _____ Age ____ Date of Birth: ___/___/___ Today's date: ___/___/___

- Have you previously passed a medical exam for sports participation for MCCC? Y N date ___/___/___
- Have you had any significant injury or illness since your last exam? Y N date ___/___/___ Are you currently ill or injured? Y N
- Have you been medically disqualified from any sport? Y N date ___/___/___
- Have you ever had any serious athletic injury, Y N date ___/___/___ explain _____
- Have you had any serious illness, Mononucleosis, etc Y N date ___/___/___
- Do you wear knee or ankle braces to participate in sport? Y N
- Have you ever had surgery? For what? Y N date ___/___/___ Have you ever been hospitalized overnight Y N date ___/___
- Have you ever been dizzy or passed out during or after exercise? Y N date ___/___/___
- Have you ever experienced a headache from being hit or falling striking your head Y N date ___/___/___
- Have you ever experienced nausea or dizziness from this hit/fall? Y N
- Have you ever experienced concentration or memory problems from this hit/fall? Y N
- Have you ever had a seizure? Y N date ___/___/___ How many concussion have you experienced ___ date ___/___
- Do you have frequent or severe headaches? (migraine) Y N
- Have you ever had a pinched nerve? Y N date ___/___/___
- Have you ever had numbness or tingling in your arms, hands, legs, or feet? Y N
- Have you ever suffered from heat exhaustion or heat stroke? Y N date ___/___/___
- Have you had any family members with premature death due to heart problems? Y N
- Do you currently take prescription medications? Y N Please list _____,_____,_____
- How often do you take Tylenol, Motrin, or advil? Please list _____
- Do you have high blood pressure? Heart murmur? Y N Please list _____,_____,_____
- Do you use vitamins, or supplements Y N
- Have you been tested for Sickel cell? Y N
- Do you have asthma, allergies, or allergic reactions? Y N Please list _____,_____,_____
- Do you feel stressed out? Y N Please explain _____
- Do you wear glasses or contact lenses? When was your last tetanus shot? Date ___/___/___
- Do you have health insurance Y N
- Females:**
- Any menstrual irregularities (skipped periods, PMS, pain)? Y N
- How many periods have you had in the last year? ____ What is the longest time between periods in the last year? ____
- Are you worried about any problems or conditions at this time? Y N

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

Athlete Signature: _____ **Student ID** _____