LOYOLA CLUB SPORTS PROGRAM – HEALTH SCREEN FORM

Name:_____ Age:_____ Sex (Circle): Male Female

Club:_____ Student ID:_____

NOTE – IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING, PLEASE PROVIDE DETAILS IF REQUESTED (DATES, EXPLANATION)

	Yes	No	
Have you had a physical within one year?	_____	_____	If yes, date:_____
Do you currently have a medical issue requiring treatment?	_____	_____	If yes, explain:_____
Do you want to see a physician about a problem or injury?	_____	_____	If yes, explain:_____
Have you been tested for the sickle cell trait and it was positive?	_____	_____	
Do you currently take any medications?	_____	_____	If yes, explain:_____
FEMALES – are you pregnant?	_____	_____	

Has anyone in **your close family** ever have/had:

Diabetes?	_____	_____
Allergies?	_____	_____
Migraines?	_____	_____
Heart trouble?	_____	_____
High blood pressure?	_____	_____

Has anyone in **your close family** died under the age of 50 suddenly?	_____	_____

Have you ever had or do you currently have:

Diabetes?	_____	_____	
Tendency to bruise/bleed easily?	_____	_____	
Anemia?	_____	_____	
Weight problems?	_____	_____	
Hepatitis?	_____	_____	
Asthma?	_____	_____	
Allergies?	_____	_____	If yes, explain:_____
Mononucleosis (mono)?	_____	_____	If yes, date:_____
Recurrent rash?	_____	_____	
Infection?	_____	_____	
Anxiety?	_____	_____	
Depression?	_____	_____	
Hernia?	_____	_____	If yes, date:_____
Kidney problems?	_____	_____	
MALES – Loss of function or absence of testicles?	_____	_____	
FEMALES – Menstrual problems?	_____	_____	
Blood in urine?	_____	_____	

Have you ever had or do you currently have:

Head injury?	_____	_____	If yes, date:_____
Concussion?	_____	_____	If yes, date:_____
Skull fracture?	_____	_____	If yes, date:_____
Neck injury?	_____	_____	If yes, date:_____
Burners/Stingers/Numbness?	_____	_____	If yes, date:_____
Convulsions or Epilepsy?	_____	_____	If yes, date:_____

Have you ever had or do you currently have:

Impaired vision in one or both eyes? _____ _____
Hearing loss or deafness? _____ _____
Discharge from an ear? _____ _____
Sinus Infection? _____ _____
False teeth/Dental plate? _____ _____
Pneumonia? _____ _____ If yes, date:_____
Perforated ear drum? _____ _____
Infectious disease? _____ _____ If yes, explain:_____

Have you ever had or do you currently have:
Bone fracture? _____ _____ If yes, date:_____
Joint dislocation? _____ _____ If yes, date:_____
Foot problems? _____ _____ If yes, date:_____
Shoulder injury? _____ _____ If yes, date:_____
Osgood-Schlatter? _____ _____ If yes, date:_____
Osteomyelitis? _____ _____ If yes, date:_____

Have you ever had or do you currently have:
Back injury or "backaches?" _____ _____ If yes, date:_____
Knee injury or pain? _____ _____ If yes, date:_____
Ankle injury or pain? _____ _____ If yes, date:_____
Other joint trouble? _____ _____ If yes, explain:_____
Bone infection? _____ _____ If yes, date:_____
Have you ever had surgery? _____ _____ If yes, explain:_____

Have you ever or do you currently:
Smoke tobacco: _____ _____
Use recreational drugs? _____ _____
Chew tobacco? _____ _____
Drink alcohol? _____ _____
Fast/Fasted (not eat for days)? _____ _____

Have you ever had or do you currently have:
Bulimia? _____ _____ If yes, date:_____
Anorexia? _____ _____ If yes, date:_____

Have you ever been treated for an
emotional issue/problem? _____ _____ If yes, explain:_____

Have you ever been told by a physician
to give up any activity because
of health problems? _____ _____ If yes, explain:_____

Do you wish to discuss an emotional
problem with a clinician? _____ _____

Please make any further notes below:

All information shared in this health screening form will be kept confidential.