



LISBON BULLSHARK SWIM TEAM PRE-PARTICIPATION HEALTH HISTORY

Swimmers Name: (Last, First, Middle)	Sex. Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of Birth dd/mm/yyyy	Age:
Emergency Phone: (Parent/Guardian)	
Name of Clinic or Provider	

	Yes	No
Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Are you presently under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>
Are you presently taking any medicine or herbal products?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any allergies (medicine, bees or other stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told that you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family died of heart problems or a sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family had Marfan's syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any skin problems (itching, rashes, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out or unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have, or have you ever had fainting spells?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had heat cramps, heat illness or muscle cramps?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble breathing or do you cough during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints	<input type="checkbox"/>	<input type="checkbox"/>
Head Shoulder Thigh Neck Elbow Knee Foot Forearm Shin/Calf Back Wrist Ankle Hip Hand		
Have you had any other medical problems (infectious mononucleosis, diabetes, anemia, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a medical problem or injury since your last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>
When was your last tetanus shot?	<input type="checkbox"/>	<input type="checkbox"/>

Explain "Yes" answers (may use back if more space is needed): _____

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

Date: _____ Signature of Athlete: _____

Date: _____ Signature of Parent: _____