

Health Maintenance Questionnaire



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	ENTS:									h Date:	•	today:	
REAS	ON FOR TH	IS CHECK UP	P: ∐Scho	ool Spor	ts	Routin	ne check-up [Gra	ade: S	School:		
1.1.1		1 4				DI	CONC		1				
	ncerns yo	u have: 1.				head	e cneck any □nose	Dody areas	that concern y □kidnevs	/ou: □bones	□brain	hormones	
2. 3.						eyes	mouth	lungs	☐genitals	□joints	nerves		
3.						ears	throat	intestines		muscles	mental		nunity
LEAR	NING &	BEHAVIO	R			H	EALTH & S	SAFETY					
	o you live w					Do	your friend	s:	Yes No		Yes No		Yes No
Do you	get along	with your par	rents or c	ustodians?				or use tobacco		Do you?		Family members?	
What a	ctivities are	you involve	d in and				-sniff glue o	r use inhalants		Have you?		Family members?	
		like to	do for fun	?				-drink alcoho		Have you?		Family members?	
Learnir	ng or behav	ior problems	at schoo	l:				-use drugs		Have you?		Family members?	
Do you	have troub	ole making o	r keeping	friends?			A					ly? No guns in home	
	get into fig		_	_	_			Do you	nave smoke	detectors and a	a fire escap	e plan at your house?know how to swim?	
		ccellent (Good 🔲	Fair □Poo	r Failing				wear a	helmet when vo	ou ride a hil	ke? ☐ don't ride one.	
Commo	ents:								wear a	nemiet when yo		vays wear a seat belt?	
									Have you ev	er been abused		ohysically or sexually?	
		Gynecolo	av aues	tions		Yes No	Gyneo	cology educ		or boom abacca	a vorbany, p	origoroung or coxeany.	
Do vo	u have que	estions or co			riods?					he first 2 years.			
					r discharge?					the year befor		period.	
					your breast?					oing self-breast			
					PAP smear?							ex or any concerns.	
	l	Do you have	questions	about sexu	uality?					3 years of having	ng sex.		
							-The Gard	dasil vaccine p	revents cervica	al cancer.			
Explair	n questions	answered w	ith "yes."	Give approx	imate dates.								
													'
							PH(ე-9					
Not	Carranal	More	Nearly	0									
	Several			Over tr	ne last 2 v	reeks.	how ofte	n have vo	u				
at All	Several Days	Than Half	Every					n have yo lowing pr					
at All	Days	the Days	Every Day	been b	othered b	y any	of the fol	n have yo lowing pro					
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Student Preparticipation Medical History

4501 So.70th St, Ste.110 Lincoln, NE 68516 Phone: 402-489-3834

STUDENT NAM	E				 FEMALE
BIRTH DATE	/	/	GRADE	AGE	
SCHOOL		ACT	IVITY		

STUDENT MEDICAL QUESTIONNAIRE							
*Circle questions you don't know the answers to. Explain "Yes" answers below.							
Everyone		Complete this column					
completes this column.	Yes No	for SPORTS participation.	Yes No				
Have you seen doctor outside of LPG for any reason?		11. Have you: had a sprain, strain or swelling after an injury?					
Do you have a recurrent medical or psychological problem? Heathers been a medical illness as injury since the left sheet up?		broken or fractured any bones or dislocated any joints?					
Has there been a medical illness or injury since the last check-up?		had pain or swelling in muscles, tendons, bones or joints? If yes, check the box and explain. EXPLAIN:					
2. Have you ever: been hospitalized overnight? had surgery?		If yes, check the box and explain. EXPLAIN: ☐ Head ☐ Shoulder ☐ Hip					
3. Are you currently using: an inhaler?		Neck □ Upper arm □ Thigh					
prescription or over-the-counter medications/pills?		☐ Back ☐ Elbow Wrist ☐ Knee					
supplements or vitamins to gain or lose weight?		☐ Chest ☐ Forearm ☐ Shin/Calf					
or to improve athletic performance?		☐ Hand ☐ Ankle	I				
4. Do you: want to weigh more or less than at present?		☐ Finger ☐ Foot					
lose weight regularly to meet weight requirements for a sport?		12. Do you use any special protective or corrective equipment	Yes No				
avoid any foods groups? (fruit/veg, meat, milk/dairy, fats, bread/grain)		or devices that aren't usually used for their sport or position?					
5. Have you had any problems with your eyes or vision?		(ex: knee brace, neck roll, foot orthotics, teeth retainer or hearing aid)					
your hearing?		13. Have you had a severe viral infection					
Has it been more than 1 year since your last dental check-up?		(ex: myocarditis or mononucleosis) within the past month? 14. Has a physician ever denied or restricted participation in					
What is your source of fluoride? ☐no known fluoride ☐not sure ☐city wa	otor	sports for any heart problems?					
fluoride rinse / recs from dentist natural fluoride in water source fluoride		15. Have you ever: had a head injury or concussion?					
6. Do you have any current skin problems		been knocked out, become unconscious or lost your memory?					
(ex: itching, rashes, acne, warts, fungus or blisters)?		had a seizure?					
7. Are there allergies to pollen, medicine, food, stinging insects?		had a stinger, burner or pinched nerve?					
Does this require medical treatment?		16. become ill from exercising in the heat?					
Have you been diagnosed with asthma?		17. Do you: have frequent or severe headaches?					
During or after exercise: -have you ever developed a rash or hives?		ever have numbness, tingling in arms, hands, legs, or feet?					
8do you cough, wheeze or have trouble breathing?		18. Do you ever feel stressed out?					
-have you ever passed out?		PLEASE EXPLAIN "YES" ANSWERS HER	5 Ŀ ·				
been dizzy?		I LLAGE LAI BAIN 120 ANOMERO	\ L .				
had chest pain ?							
Do you get tired more quickly than friends do during exercise?		1					
9. Have YOU ever: been told you have a heart murmur?		1					
had racing of their heart or skipped heartbeats?			I				
had high blood pressure or elevated cholesterol? 10. Has a RELATIVE: -had diabetes?		4					
-been very obese?		1	I				
-had high cholesterol?		1					
-died of heart problems or of sudden death before age 50?							
-been diagnosed with: long Qt Syndrome?		1					
hypertrophic cardiomyopathy (thick heart)?		1					
Marfan's Syndrome?							
14. FEMALES ONLY: Have not had a period. Skip this section.		I hereby state that, to the best of my knowledge, my answers to the					
When was the: first menstrual period?	ŀ	questions are complete and correct. The information provided her					
most recent period?	ŀ	be shared with other school personnel as needed to promote the c safety and educational success at school.	chila's				
How much time usually passes between	ŀ	Signed:					
the <u>start</u> of one period and the <u>start</u> of the next?	ŀ	9					
What was the longest time between periods this past year? How many periods have you had in the past year?	ŀ	Student					
How many days does your period usually last?	ŀ	Parent/guardian					
Do you get cramps which interfere with activities?	ŀ	i dient/guardian					
If yes, what medications have you tried?	I	DATE					