Sports Physical Health Risk Assessment Form

Full Name

Date of Birth

Sport

Emergency Contact Name & Phone

Medical History

Have you ever been diagnosed with any of the following?

- [ ] Asthma
- [ ] Diabetes
- [ ] Epilepsy/Seizures
- [ ] Heart Disease
- [ ] None

Other medical conditions (if any)

Are you currently taking any medications?

- ( ) Yes
- ( ) No

If yes, please list them

Do you have any allergies?

- ( ) Yes
- ( ) No

If yes, please specify

Family History

Any family history of medical conditions? (e.g. heart disease, sudden death under age 50)

Physical Symptoms

Have you experienced any of the following?

- [ ] Fainting during exercise
- [ ] Chest pain/tightness
- [ ] Unexplained dizziness
- [ ] Shortness of breath
- [ ] None

Past injuries or surgeries (including dates)

Other concerns or relevant information