

**2011 - 2012**  
**GOYA MEDICAL HISTORY QUESTIONNAIRE**

GOYAN'S NAME: \_\_\_\_\_  
TODAY'S DATE: \_\_\_\_\_

Please indicate with a checkmark if your child has a history of any of the following and provide the date and details.

- |   |  |
|---|--|
| <input type="checkbox"/> Concussion or Head injury (number)       | <input type="checkbox"/> Asthma                                    |
| <input type="checkbox"/> Loss of consciousness after injury       | <input type="checkbox"/> Lactose Intolerant                        |
| <input type="checkbox"/> Seizures                                 | <input type="checkbox"/> Diabetes (Type) _____                     |
| <input type="checkbox"/> Skull fracture                           | <input type="checkbox"/> Fatigue or Undue Tiredness                |
| <input type="checkbox"/> Headaches/Migraines                      | <input type="checkbox"/> Tendency to Bruise Easily                 |
| <input type="checkbox"/> Broken Nose                              | <input type="checkbox"/> Skin Condition                            |
| <input type="checkbox"/> Sinus Infections                         | <input type="checkbox"/> Gastrointestinal Problems                 |
| <input type="checkbox"/> Ear Infections / Conditions              | <input type="checkbox"/> Ulcer or Recurrent Abdominal Pain         |
| <input type="checkbox"/> Chest Pains or Palpitations w / exercise | <input type="checkbox"/> Hernia                                    |
| <input type="checkbox"/> Low / High Blood Pressure                | <input type="checkbox"/> Kidney Disease                            |
| <input type="checkbox"/> Heart Defect / Murmur                    | <input type="checkbox"/> Bladder/Urinary Tract Infections          |
| <input type="checkbox"/> Neck Injury / Recurrent Pain             | <input type="checkbox"/> Menstrual Concerns / Problems             |
| <input type="checkbox"/> Back Injury / Recurrent Pain             | <input type="checkbox"/> Condition Affecting Balance/ Coordination |
| <input type="checkbox"/> Hip / Pelvic Injury / Recurrent Pain     | <input type="checkbox"/> Fainting Spells                           |
| <input type="checkbox"/> Knee Injury / Recurrent Pain             | <input type="checkbox"/> Wears Contact Lenses                      |
| <input type="checkbox"/> Ankle / Foot Injury / Recurrent Pain     | <input type="checkbox"/> Wears Glasses                             |
| <input type="checkbox"/> Shoulder / Injury / Recurrent Pain       | <input type="checkbox"/> Wears Braces                              |
| <input type="checkbox"/> Elbow / Injury/ Recurrent Pain           | <input type="checkbox"/> Other                                     |
| <input type="checkbox"/> Wrist / Hand Injury / Recurrent Pain     | <input type="checkbox"/> Hospitalization (dates and reasons)       |
| <input type="checkbox"/> Fractures (part & date) _____            | _____  |
| <input type="checkbox"/> Joint Dislocation _____                  | <input type="checkbox"/> Surgery (type & date) _____               |

Date of Most Recent Tetanus Injection : \_\_\_\_\_ ( must be provided)

Has your child been advised not to participate in any sport or athletic activity? If yes, please explain: \_\_\_\_\_

Please list ALL allergies here: \_\_\_\_\_

Please list any prescription, over-the-counter medication(s) or herbal remedies taken by your child: \_\_\_\_\_

Are there any other medical concerns/problems of which we should be aware?

\_\_\_\_\_  
\_\_\_\_\_