PNRA/Mercer Masters
Participant Information/Health Questionnaire

LAST NAME_____ FIRST NAME_____ MIDDLE I.___
ADDRESS_____ CITY_____STATE_____ ZIP_____
EMAIL_____
DATE OF BIRTH (MM/DD/YYYY) _____ SEX M___ F___
PHONE H _____ W _____ Cell_____

MEDICAL HISTORY QUESTIONNAIRE

PLEASE CIRCLE "**NO**" OR "**YES**" AND PROVIDE ADDITIONAL DETAILS WHERE REQUESTED ON THIS FORM. ALL INFORMATION WILL BE CONFIDENTIAL.

1. Are you allergic to any medication (aspirin, penicillin, sulfa, etc)? **NO YES** (list)

2. Do you take any prescribed medication on a permanent or semi-permanent basis (steroids, birth control pills, Anti-inflammatory, antibiotics, etc.)? **NO YES** (List and give reason)

3. Have you ever had an epileptic seizure? **NO YES**

4. Have you ever been told by a doctor that you have epilepsy? **NO YES** (List medication)

5. Have you ever been treated for diabetes? **NO YES**

6. Have you ever been told by a doctor that you were anemic **NO YES** When?

7. Have you ever been told by a doctor that have sickle cell anemia? **NO YES**

8. Do you or have you ever had high blood pressure? **NO YES** (List medication)

9. Have you experienced a heart attack or have been told by a doctor that you are at high risk for a heart attack?
NO YES

10. Do you or have you ever had the following diseases?

NO YES (give date) heart disease (heart murmur, rheumatic fever)
NO YES (give date) lung disease (pneumonia)
NO YES (give date) kidney disease (infectious)
NO YES (give date) liver disease (mononucleosis, hepatitis)

11. Do you or have you ever been told by a doctor that you have asthma? **NO YES** (list medication)

12. Do you or have you ever had a hernia? **NO YES** Has it been repaired? Date

13. Have you ever been "knocked out" (unconscious) in the past 3 years? **NO YES** (list dates)

14. Have you had a concussion or other head injury in the past 3 years? **NO YES** (list dates)

15. Have you ever injured your back? **NO YES** Type of Injury Date

16. Do you have back pain? **NO YES** (circle those that apply) SELDOM / OCCASIONALLY / FREQUENTLY

17. Do you have other conditions that we should be aware of (i.e. ulcers, pregnancy, food or insect allergies, tendonitis, etc.)?
NO YES (List and give details)

THE ABOVE QUESTIONS HAVE BEEN ANSWERED COMPLETELY AND TRUTHFULLY TO THE BEST OF MY KNOWLEDGE.

SIGNATURE_____ DATE_____

Swim Competency

I certify that I am able to swim _____

I am comfortable in and around water _____