Dance Dimensions Medical History Questionnaire

General Information

Student's Name: _____ Date of Birth: _____
Address: _____ Home Phone Number: _____
Emergency Contact: _____ Phone Number: _____
Physician's Name: _____ Date of last visit: _____

Which of the following conditions is the student currently being treated for or has the student been treated for in the past?

☐ Heart diseases/murmur/angina	☐ Shortness of breath	☐ Asthma
☐ High blood pressure	☐ Low blood pressure	☐ Heartburn/acid reflux
☐ Anemia/blood problems	☐ Swollen ankles	☐ Lung problems/cough
☐ Sinus Problems	☐ Seasonal allergies	☐ Seizures
☐ Headaches/migraines	☐ Depression/anxiety	☐ Ear problems
☐ Diabetes	☐ Cancer	☐ Dizzy spells/fainting
☐ Stomach/gastrointestinal issues	☐ Skin issues	
☐ Learning disabilities (e.g., ADD, ADHD, dyslexia, etc.)		

To the extent it would be helpful in treating or diagnosing an injury, please explain any of the above, or indicate any conditions not listed above:

_____

_____

Please list all past surgeries and/or orthopedic issues:

_____

_____

Please list all allergies to foods and/or medications:

_____

_____

Please list any other information that would be helpful in the case of an injury or emergency:

_____

_____

Please list any medications the student is taking long term:

_____

_____ _____

Signature of parent/guardian **Date**