MEDICAL HISTORY QUESTIONAIRE

NAME ____
Last First Middle

ADDRESS ____
Street City State Zip Code

Date of Birth _____________ Sex _______ Phone ______________

Emergency Contact _______________________________________

Home Ph ____________ Wk Ph ____________ other __________

Circle the Correct Answer. All information will be confidential.

Yes No 1. Are you allergic to any general medication (aspirin, sulfa, penicillin, etc.)? If so, please indicate what medication.

Yes No 2. Are you currently on prescribed medication on a permanent or semi-permanent basis (birth control pills, steroids, etc.)? If so, please indicate name of medication and why prescribed.

Yes No 3. Have you ever experienced an epileptic seizure or been informed that you might have epilepsy?

Yes No 4. Have you ever been treated for diabetes? If so, please indicate the type(s) of insulin or pills you use.

Yes No 5. Has a medical doctor ever told you that you were anemic or had sickle cell anemia?

Yes No 6. Do you have or have you ever had high blood pressure? If so, list any medication for it you take regularly.

Yes No 7. Do you have or have you ever had the following diseases? If so, please circle the appropriate ones. Heart disease (rheumatic fever). Lung disease (pneumonia). Kidney disease (infections). Liver disease (hepatitis).

Yes No 8. Have you ever been informed by a medical doctor that you have asthma? If so, what medications, if any, do you regularly take?

Yes No 9. Do you presently have an unrepaired hernia?

Yes No 10. Have you ever been "knocked out" or experienced a concussion during the past 3 years? If so, give the dates of each.

Yes No 11. If the answer to question 10 is yes, did the attending physician have you stay overnight in a hospital? If yes, give the dates and details of each.

Yes No 12. Have you ever had an injury to your neck involving nerves, vertebrae (bones), or discs that incapacitated you for a week or longer? If yes, give the dates of each.

Yes No 13. Do you wear eyeglasses or contacts during athletic participation?

PLEASE CONTINUE ON BACK OF THIS PAGE. THANK YOU

Yes No 14. Do you wear any dental appliance? If yes, circle the appropriate appliance: Permanent bridge. Permanent crown or jacket. Removable partial plate. Braces. Permanent retainer. Removable retainer.

Yes No 15. Have you had a fracture during the past 2 years? If so, indicate which bone was broken and the date it happened.

Yes No 16. Have you had a shoulder dislocation, separation, or other shoulder injury during the past 2 years that incapacitated you for a week or longer? If so, give the dates of the injury.

Yes No 17. Have you ever had surgery to correct a shoulder condition? If so, give the date and what was done.

Yes No 18. Have you ever had an injury to your back?

Yes No 19. Do you experience pain in the back? If yes, indicate frequency: Seldom. Occasionally. Frequently. With vigorous exercise. With heavy exercise.

Yes No 20. Have you ever injured your knee during the past 2 years with severe swelling accompanying the injury?

Yes No 21. Have you ever been told that you injured the ligaments and/or cartilages of either knee?

Yes No 22. Have you ever been advised to have surgery to correct a knee problem?

Yes No 23. If the answer to question 22 is yes, has the surgery been completed? Please give date(s).

Yes No 24. Have you experienced a severe sprain of either ankle during the past 2 years?

Yes No 25. Do you have a pin, screw, or plate somewhere in your body as a result of bone or joint surgery? If yes, indicate where in your body and the date of the surgery.

Yes No 26. Do you have any chronic conditions that have not been mentioned above? If yes, please explain.

ALL THE QUESTIONS OF THIS FORM HAVE BEEN ANSWERED COMPLETELY AND TRUTHFULLY TO THE BEST OF MY KNOWLEDGE.

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Signature of Athlete Date