

C. MEDICAL HISTORY:

1. Height: _____ 2. Weight: _____ 3. Weight change in past 6 months: _____
 4. Date of last Tetanus booster: _____

5. DO YOU NOW HAVE OR HAVE YOU EVER HAD: Please circle Y or N and provide date.

DATE			DATE				
Y	N	_____	ANEMIA	Y	N	_____	INFLUENZA
Y	N	_____	APPENDICITIS	Y	N	_____	JAUNDICE
Y	N	_____	ARTHRITIS	Y	N	_____	KIDNEY STONE
Y	N	_____	ASTHMA	Y	N	_____	KIDNEY DISEASE
Y	N	_____	ATHLETE'S FOOT	Y	N	_____	LIVER DISEASE
Y	N	_____	BONE DISEASE	Y	N	_____	LUPUS
Y	N	_____	BOILS	Y	N	_____	MALARIA
Y	N	_____	CANCER	Y	N	_____	MEASLES
Y	N	_____	CHICKEN POX	Y	N	_____	MELANOMA
Y	N	_____	COLITIS	Y	N	_____	MIGRAINES
Y	N	_____	CONCUSSION	Y	N	_____	MONONUCLEOSIS
Y	N	_____	DIABETES	Y	N	_____	MUMPS
Y	N	_____	DIPHThERIA	Y	N	_____	NEURITIS
Y	N	_____	ENLARGED SPLEEN	Y	N	_____	NEURALGIA
Y	N	_____	RUPTURED SPLEEN	Y	N	_____	PLEURISY
Y	N	_____	EPILEPSY	Y	N	_____	PNEUMONIA
Y	N	_____	GALL BLADDER	Y	N	_____	PNEUMOTHORAX
			DISEASE	Y	N	_____	RHEUMATIC FEVER
Y	N	_____	GERMAN MEASLES	Y	N	_____	RHEUMATISM
Y	N	_____	GI TRACT	Y	N	_____	SCARLET FEVER
			INFECTION	Y	N	_____	TETANUS SHOT
Y	N	_____	GOUT	Y	N	_____	THYROID DISEASE
Y	N	_____	HAY FEVER	Y	N	_____	TUBERCULOSIS
Y	N	_____	HEMORRHOIDS	Y	N	_____	ULCER
Y	N	_____	HEPATITIS	Y	N	_____	VARICOSE VEINS
Y	N	_____	HERNIA	Y	N	_____	WHOOPING COUGH
Y	N	_____	HYPOGLYCEMIA	Y	N	_____	OTHER

PLEASE EXPLAIN "YES" ANSWERS, INCLUDING: DATE, PHYSICIAN NAME, PHONE #, SURGICAL PROCEDURES, TREATMENT RECEIVED, RESULTS, ETC.

6. HAVE YOU EVER HAD ANY OF THE FOLLOWING SYMPTOMS?

Y	N	BLURRED VISION	Y	N	FAINING SPELLS
Y	N	BLOOD IN URINE	Y	N	FATIGUE EASILY
Y	N	BLOOD IN STOOL	Y	N	FLUTTERING HEART
Y	N	BURNING WITH URINATION	Y	N	FREQUENT COLDS
Y	N	CHEST PAIN	Y	N	FREQUENT CONSTIPATION
Y	N	CNSTIPATION	Y	N	FREQUENT COUGHS
Y	N	COUGHING BLOOD	Y	N	FREQUENT DIARRHEA
Y	N	CONVULSIONS/SEIZURES	Y	N	FREQUENT HEADACHES
Y	N	DEPRESSION/ANXIETY	Y	N	FREQUENT NAUSEA
Y	N	DIARRHEA	Y	N	FREQUENT SORE THROATS
Y	N	DIFFICULTY WITH URINATION	Y	N	HALLUCINATIONS
Y	N	DIZZINESS	Y	N	HEADACHE AFTER GAMES
Y	N	ENLARGED GLANDS	Y	N	HEARING LOSS
Y	N	EXCESSIVE CRAMPING	Y	N	INDIGESTION
Y	N	EXCESSIVE BLEEDING	Y	N	NOSEBLEEDS
Y	N	EYE INJURY	Y	N	PARALYSIS

Y N SHORTNESS OF BREATH
Y N UNCONSCIOUSNESS

Y N LOSS OF VISION

PLEASE EXPLAIN "YES" ANSWERS, PLEASE INCLUDE: FREQUENCY, TREATMENT RECEIVED, ETC.

7. ALLERGIES:

Are you allergic to? Please circle, Y=Yes/ N=No.

Y	N	ASPIRIN	Y	N	LATEX PRODUCTS
Y	N	CODEINE	Y	N	ANESTHESIA
Y	N	MORPHINE	Y	N	OTHER DRUGS
Y	N	COSMETICS	Y	N	BEE/INSECT STINGS
Y	N	OTHER ANTIBIOTICS	Y	N	PENICILLIN
Y	N	ANY FOODS	Y	N	OTHER ALLERGIES
Y	N	ADHESIVE TAPE			

Please explain yes answers (type of reaction, control methods, etc.):

List any allergies not listed above:

8. CARDIAC

Are you aware of having or ever having?

Y	N	Heart murmur	Y	N	Dizziness
Y	N	High blood pressure	Y	N	Passing out
Y	N	Low blood pressure	Y	N	Chest pain
Y	N	Irregular heart beat	Y	N	Excessive fatigue
Y	N	Heart disease	Y	N	Chest pains with exercise
Y	N	Heart palpitations	Y	N	Other _____

Are you currently taking any medications for any of the above conditions or any other cardiac condition not listed?
If yes, please list: Medication _____ Physician _____ Phone # () _____

Do you have an immediate family member that suffers from a cardiac condition? Please explain: _____

Have you had any cardiac tests or screening procedures done? Procedure _____ Date _____
Physician _____ Phone # _____ Results _____

9. HEAT ISSUES

Y N Have you ever suffered from heat exhaustion? Date _____
Y N Have you ever suffered from heat stroke? Date _____
Y N Were you hospitalized?
How long did you stay out of competition? _____
Physician's name _____ Phone # _____
Y N Do you have or have you ever had trouble with dehydration?

COMMENTS:

10. SURGERY

Y N Hernia repair Physician _____ Phone # _____ Date _____
Y N Appendectomy Physician _____ Phone # _____ Date _____
Y N Other (non-orthopaedic) Please explain in COMMENTS:

COMMENTS:

11. IMMUNIZATIONS

Y N _____ MMR Y N _____ Polio
Y N _____ Diphtheria Y N _____ German Measles
Y N _____ Influenza Y N _____ Others
Y N _____ Tetanus

12. EYES

Y N Do you lack vision in one eye?
Y N Do you have diminished or abnormal vision?
Y N Do you wear prescription glasses?
Y N Do you wear contact lenses? Hard _____ Soft _____ Gas Permeable _____ Other _____
Y N Date of last eye exam _____ Optometrist's Name _____
Phone # () _____
Y N Have you ever had an eye injury or surgery? Right _____ Left _____
If yes, please list physician/surgeon's name _____ Office Phone # () _____

COMMENTS:

13. EAR/NOSE/THROAT/DENTAL

Y N Do you have any hearing impairments?
Y N Do you ever experience ringing in your ears?
Y N Have you ever had an ear injury or surgery? Right _____ Left _____
If yes, please list physician/surgeon's name _____ Office Phone # () _____
Date _____
Y N Do you experience frequent nose bleeds?
Y N Have you ever had a nose injury or surgery? Date _____
If yes, please list physician/surgeon's name _____ Office Phone # () _____
Y N Do you have any false teeth or dental plates or bridges? (circle)
Y N Have you had your wisdom teeth removed? How many? _____
Y N Have you ever fractured a tooth or had a tooth knocked out? If yes, explain: _____
If yes, please list dentist's name _____ Office Phone # () _____

COMMENTS:

14. HEAD INJURY—any YES answers need to be explained in COMMENTS section.

- Y N Have you ever had or been recommended to have a CT scan, brain scan, skull x-ray?
 Y N Have you ever had or been recommended to have an electroencephalogram/EEG?
 Y N Have you ever had a loss of memory (amnesia) following a head injury?
 Y N Have you ever been knocked out, unconscious, passed out, fainted, or blacked out?
 How long? Less than 5 minutes _____
 5 to 15 minutes _____
 More than 15 minutes _____
 What activity/sport(s) were you participating in when this happened? _____
 Physician/Surgeon's Name _____ Phone # () _____
 Were you admitted into a hospital/clinic? Name of facility _____
 When did you resume activity following your injury? (Days/weeks?) _____
- Y N Have you ever had a seizure, convulsion, or an epileptic attack?
 Y N Have you ever suffered a concussion? How many times? _____
 What activity/sport(s) were you participating in when this happened? _____
 Physician/Surgeon's Name _____ Phone # () _____
 Were you admitted into a hospital/clinic? Name of facility _____ Date _____
 When did you resume activity following your injury? (Days/weeks?) _____

COMMENTS:

15. NECK/SPINE

- Y N Have you ever had an injury to your neck or spine? How many times? _____
 Y N Have you ever fractured a vertebrae in your spine?
 Y N Has anyone ever told you that you have any spine defects that have been there since birth, such as spondylolisthesis, spondylolysis, etc? Please explain in COMMENTS area.
 Y N Have you ever had x-rays taken? Please explain in COMMENTS area.
 Y N Were you seen by a physician or admitted into a hospital or clinic? Explain in COMMENTS area.
 Y N After the injury, how long until you were allowed to return to activity? _____
 Y N Have you ever had a "burner" or "stinger"?
 Y N Did you have numbing/tingling/burning in your hands? How often? _____
 Y N Have you injured your spine more than once?
 Y N Have you seen a physical therapist or certified athletic trainer for any neck or spine injury?
 Name _____ Phone # () _____
 Y N List any other injuries or neck/spinal conditions that you may have? (Slipped disc, scoliosis, neurological conditions, etc.)
 Y N List any surgeries that you have had that involved the neck or spine. Surgery _____
- | | | |
|-----------|------|-------|
| Physician | Date | Phone |
| Street | City | State |
| | | Zip |

COMMENTS:

16. UPPER EXTREMITY

- Y N Have you ever fractured your humerus, scapula, clavicle, ulna, radius, wrist, hand, or fingers?
 Which bone(s)? Circle involved side: L/R _____ L/R _____ L/R _____
 Y N Have you ever dislocated your shoulder, acromioclavicular (AC) joint, sternoclavicular joint, elbow, wrist, hand, or fingers? Which joint(s)? Circle involved side and list how many times:
 L/R _____ L/R _____ L/R _____ L/R _____ L/R _____

- Y N** Have you sprained any of the above joints and kept out of your sport for at least one day?
 L/R _____ Time out _____
 L/R _____ Time out _____
 L/R _____ Time out _____
 L/R _____ Time out _____
 L/R _____ Time out _____
- Y N** Do any of these injuries frequently occur? If yes, please list:
 L/R _____ L/R _____ L/R _____ L/R _____ L/R _____
- Y N** Have you ever had x-rays or an MRI on any of the above mentioned joints/bones?
 L/R _____ L/R _____ L/R _____ L/R _____ L/R _____
- Y N** Have you ever had any surgery for the above joints/bones?
 If yes, please list: Surgery R/L _____ Physician/surgeon's name _____
 Office Phone # () _____ Date _____
 Surgery R/L _____ Physician/surgeon's name _____
 Office Phone # () _____ Date _____
 Surgery R/L _____ Physician/surgeon's name _____
 Office Phone # () _____ Date _____
- Y N** Have you seen a physical therapist or certified athletic trainer for any upper extremity injury?
 Injury R/L _____ Name _____
 Phone # () _____
 Injury R/L _____ Name _____
 Phone # () _____

COMMENTS:

17. RIB/STERNUM

- Y N** Have you ever fractured, separated, or had any other significant injury to a rib, sternum, or cartilage? Please explain. _____

- Y N** Have you sprained/injured any of the above joints and kept out of your sport for at least one day?
 L/R _____ Time out _____
 L/R _____ Time out _____
- Y N** Do any of these injuries frequently occur? If yes, please list:

- Y N** Have you ever had x-rays or an MRI on any of the above mentioned joints/bones?
 L/R _____ L/R _____ L/R _____ L/R _____ L/R _____
- Y N** Have you ever had any surgery for the above joints/bones?
 If yes, please list: Surgery R/L _____ Physician/surgeon's name _____
 Office Phone # () _____ Date _____
 Surgery R/L _____ Physician/surgeon's name _____
 Office Phone # () _____ Date _____
- Y N** Have you seen a physical therapist or certified athletic trainer for any rib/sterum injury?
 Injury R/L _____ Name _____
 Phone # () _____

18. LOWER EXTREMITIES

- Y N** Have you ever fractured your pelvis, femur (thigh), patella (kneecap), tibia, fibula, ankle, foot, or toes? Please list each fracture: L/R _____ L/R _____
L/R _____ L/R _____ L/R _____
- Y N** Have you ever dislocated your hip, knee, patella, ankle, foot, or toes? Please list:
L/R _____ L/R _____ L/R _____
- Y N** Have you had any significant injury that kept you out of your sport for more than one day?
L/R _____ Time out _____
L/R _____ Time out _____
L/R _____ Time out _____
L/R _____ Time out _____
L/R _____ Time out _____
- Y N** Do any of these injuries occur often? _____
- Y N** Have you ever had x-rays of any of the above bones/joints?
L/R _____ L/R _____ L/R _____
- Y N** Have you ever had any surgery for the above joints/bones?
If yes, please list: Surgery R/L _____ Physician/surgeon's name _____
Office Phone # () _____ Date _____
Surgery R/L _____ Physician/surgeon's name _____
Office Phone # () _____ Date _____
Surgery R/L _____ Physician/surgeon's name _____
Office Phone # () _____ Date _____
- Y N** Have you seen a physical therapist or certified athletic trainer for any lower extremity injury?
Injury R/L _____ Name _____
Phone # () _____
Injury R/L _____ Name _____
Phone # () _____

COMMENTS:

19. MUSCLES AND TENDONS

- Y N** Have you ever had a significant muscle or tendon strain that kept you out of participation for at least one day? Please list the involved side, the muscle or group, and the amount of time out.
L/R _____ Time out _____
L/R _____ Time out _____
L/R _____ Time out _____
L/R _____ Time out _____
L/R _____ Time out _____
- Y N** Have you ever had any other significant injury (not a strain or pull) that kept you out for at least one day?
L/R _____ Injury _____ Time out _____
L/R _____ Injury _____ Time out _____
L/R _____ Injury _____ Time out _____
- Y N** Do any of these injuries occur frequently? _____
- Y N** Have you ever had any surgery for any muscle or tendon injury?
If yes, please list: Surgery R/L _____ Physician/surgeon's name _____
Office Phone # () _____ Date _____
Surgery R/L _____ Physician/surgeon's name _____
Office Phone # () _____ Date _____

Y N Have you seen a physical therapist or certified athletic trainer for any muscle or tendon injury?
Injury R/L _____ Name _____
Phone # () _____
Injury R/L _____ Name _____
Phone # () _____

20. MALE ATHLETES

Y N Have you ever lost a testicle?
Y N Have you ever had prostate cancer/problems?
Y N Have you ever experienced penile discharge?
Y N Have you ever had an undescended testicle?

COMMENTS:

21. FEMALE ATHLETES

Y N Have you ever been pregnant?
Y N Have you ever had an injury to your breasts?
Y N Have you ever had surgery on your breasts?
Y N Have you ever had lumps on your breasts?
Y N Have you ever had surgery on your ovary/ovaries or uterus?
Y N Do you have any menstrual problems?
Y N Have you ever had an abnormal pap smear? Date of last pap smear: _____
Please explain: _____
Date of your last period: _____ Longest time between periods: _____

COMMENTS:

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I hereby state that my answers to these questions are correct to the best of my knowledge.

Signature of Athlete _____ Date _____

Signature of Parent/Guardian _____ Date _____