

MEDICAL HISTORY QUESTIONARE

PLAYER INFORMATION:

First Name:			Last Name:			
Date of Birth: _	//	Age:	Sex:	Phone:()	
Emergency Contact:			Relationship:		_ Phone:(_)
			ST DETAILS AS RE PPLIED ONLY TO			
NO/YES	Do you hav	e any allergies? ((Foods, medications, e	etc.) Please list:		
NO/YES	Do you regularly take any over the counter and/or prescription medication? Please list and provide reasons:					
NO/YES	provide reasons:					
	Have you ever been diagnosed with any major diseases or conditions? (diabetes, epilepsy, heart					
NO/YES	disease, etc.) List:					
NO/YES	Have you ever been knocked out or had a concussion or other closed head injury?					
NO/YES	List dates: Have you ever injured the bones, ligaments, nerves, or discs of your neck and back that disabled you for a week or longer? List injury/dates:					
NO/YES	Have you ever had a broken bone or fracture? Right or Left List bones/dates:					
NO/YES	Have you ever had a shoulder/elbow or wrist injury that disabled you for a week or longer? R or I					
NO/YES	List injury/dates: Have you ever injured the ligaments in your knee? Right or Left List injury/dates:					
NO/YES	Have you ever had an ankle injury that disabled you for a week or longer? (dislocation, sprain, separation, etc.) Right or Left List injury/dates:					
NO/YES	Do you presently have a rod, pin, screw, or plate anywhere in your body? Where: List injury/dates:					
NO/YES	Do you wear contact lenses or removable dental appliances while participating in your sport? List items:					
NO/YES	Have you experienced any major surgery? List:					
NO/YES	Are you current on all immunizations? List special considerations:					
NO/YES	Do you hav	e any other condi	tions you wish to mak	e us aware? Pl	ease specify a	and give details:
BEST OF MY	KNOWLED	GE. SIGNING T	ANSWERED COMP THIS DOCUMENT I SSARY EMERGENO	RELEASES A		
PLAYER NAME			SIGNATURE			DATE
PARENT/LEC	CAL CHARDI		SIGNATURE			— DATE