

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ CAMPUS PHONE: _____

(last) (first) (middle)

AGE: _____ HEIGHT: _____ WEIGHT: _____ BIRTH DATE: _____

SPORT: _____ DATE: _____

EYES: Do you wear:
Safety frames and lenses? Yes _____ No _____
Soft contact lenses? Yes _____ No _____
Hard contact lenses? Yes _____ No _____
Have you had any eye problems? Yes _____ No _____

HEAD: Have you ever been knocked out or had a concussion or any other head injury while playing contact sports or at any other time during your life? Please give details if possible.
Knocked out? Yes _____ No _____ Details _____
Concussion? Yes _____ No _____ Details _____
Other head injuries? Yes _____ No _____ Details _____
Recurrent headaches or dizziness? Yes _____ No _____ Details _____

NECK: Do you have a history of:
Neck injuries? Yes _____ No _____ Details _____
Burners, stinger, numbness? Yes _____ No _____ Right _____ Left _____
Details _____

BONES: Have you ever broken or cracked a bone? (Ex. collarbone, arm, leg, etc.)
Yes _____ No _____
Details _____
Worn a cast or a splint? Yes _____ No _____

SHOULDER: Injury/Dislocation/Separation/Rotator-cuff? Yes _____ No _____
Right _____ Left _____ Details _____

ARM: Injury to forearm/wrist/hand/fingers? Yes _____ No _____ Right _____ Left _____
Details _____

BACK: Do you have a history of back pain/injury? Yes _____ No _____
Details _____

KNEE: Do you have a history of:
Knee injury? Yes _____ No _____ Right _____ Left _____
Details _____
Locking/giving away? Yes _____ No _____
Details _____
Surgery? Yes _____ No _____
Do you wear a knee brace or any special equipment? Yes _____ No _____
Right _____ Left _____

HIP/THIGH: Have you ever had a strain/pulled muscle in:
Quad? Yes _____ No _____ Right _____ Left _____
Hamstring? Yes _____ No _____ Right _____ Left _____
Groin? Yes _____ No _____ Right _____ Left _____
Calf/Shin? Yes _____ No _____ Right _____ Left _____

ANKLE: Sprains that require taping? Yes _____ No _____ Right _____ Left _____
Achilles tendon injury? Yes _____ No _____ Right _____ Left _____
Details _____

Have you ever had, or do you now have:

A hernia?	Yes _____ No _____	Heat or muscle cramps or passed out in the heat?	Yes _____ No _____
A heart murmur?	Yes _____ No _____	Chest pain during or after activity?	Yes _____ No _____
Epilepsy?	Yes _____ No _____	Trouble breathing or coughing during or after activity?	Yes _____ No _____
Asthma?	Yes _____ No _____	Racing of your heart or skipped beats?	Yes _____ No _____
Diabetes?	Yes _____ No _____	Anyone in your family died of heart problems or sudden death before age 50?	Yes _____ No _____
High blood pressure?	Yes _____ No _____		
Kidney disease?	Yes _____ No _____		
Passing blood in urine?	Yes _____ No _____		
Stomach problems?	Yes _____ No _____		

Do you take any medication or pills now? Yes _____ No _____

Details _____

Do you take or use over the counter medications regularly? Yes _____ No _____

Details _____

Have you ever required surgery for any medical illness or for ANY INJURY INCLUDING CONTACT SPORTS?

Yes _____ No _____ Date _____ Doctor Name: _____

Details _____

Have you recently had "mono" or appendicitis or other acute illnesses? Yes _____ No _____

If so, what? _____

Have you had a medical problem or injury since your last evaluation or any medical illnesses which we should know about for your own protection?

Yes _____ No _____

If so, what? _____

(Parents'/Guardians' Name)

(Area Code) (Phone Number)

(Home address)

(City)

(State)

(Zip)

(Family Physician)

(Clinic)

(Phone Number)

ALL OF THE PRECEDING INFORMATION IS COMPLETE AND HONEST TO THE BEST OF MY KNOWLEDGE

SIGNED: _____

THANK YOU FOR YOUR COOPERATION!!!