



## MEDICAL HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_

Sport: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sex: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Please circle 'yes' or 'no' and provide additional details as requested on both sides of the form.  
All information is confidential.

Are you allergic to any medications? (Aspirin, penicillin, sulfa, etc.) NO YES  
If yes, please list

Are you allergic to any foods: NO YES  
If yes, please list

Are you allergic to insect bites/stings? NO YES  
If yes, please list

Are you allergic to any trees, plants, or animals? NO YES  
If yes, please list

Do you regularly take any over the counter and/or prescription medication? (steroids, birth control pills, anti-inflammatories, antibiotics, topical medications, sprays/inhalers, etc.)? NO YES  
If yes, please give reasons

Do you regularly take any vitamins, minerals, herbs, or other supplements? NO YES  
If yes, please list

Have you ever been told that you have (had) asthma or exercise induced asthma? NO YES  
If yes, list medications

Have you ever had a seizure? NO YES  
If yes, please note date of last seizure

Have you ever been told that you have epilepsy? NO YES  
If yes, list medications

Are you presently being treated for diabetes or high blood sugar? NO YES  
If yes, list medications

Have you ever been told that you were anemic? NO YES  
If yes, list dates

Have you ever been told that you have sickle cell anemia? NO YES

Have you ever been told you have sickle cell trait? NO YES

Are you presently being treated for high blood pressure? NO YES  
If yes, list medications

Do you have or have you ever had heart disease (murmur, rheumatic fever, stenosis)? NO YES  
If yes, list conditions and dates

Do you have or have you ever had lung disease (pneumonia, tuberculosis, etc.)? NO YES  
If yes, list condition and dates

Do you have or have your ever had kidney disease (infections, kidney stones, blood in urine, etc.)? NO YES  
If yes, list condition and dates

Do you have or have you ever had liver disease (mononucleosis, hepatitis, etc.)? NO YES  
If yes, list condition and dates

Do you have or have you ever had stomach disease (ulcers, bleeding, etc.)? NO YES  
If yes, list condition and dates

Do you have or have you ever had frequent headaches (migraines, tension headaches)? NO YES  
If yes, list condition and dates

Do you or have you ever had a hernia or "rupture"? NO YES  
If yes, list dates, if repaired.

Have you ever been knocked out or had a concussion or other closed head injury? NO YES  
If yes, list dates

Have you ever stayed overnight in a hospital due to a concussion of closed? head injury? NO YES  
If yes, list dates

Have you ever injured the bones, ligaments, nerves or discs of your neck that disabled you for a week or longer? NO YES  
If yes, list injury/dates

Have you ever injured the bones, ligaments, nerves or discs of your upper back that disabled you for a week or longer? NO YES  
If yes, list injury/dates

Have you ever injured the bones, ligaments, nerves or discs of your lower back that disabled you for a week or longer? NO YES  
If yes, list injury/dates

Have you ever had a broken bone or fracture? NO YES R or L  
List bone/dates

Have you ever had a shoulder injury that disabled you for a week or longer (dislocation, separation, etc.)? NO YES R or L

List injury/dates

Have you ever had shoulder surgery? NO YES R or L

What was done/why

Date(s)

Have you had an elbow injury that disabled you for a week or longer (dislocation, sprain, etc.)?

NO YES R or L

List injury/dates

Have you ever had elbow surgery? NO YES R or L

What was done/why

Date(s)

Have you had a wrist or hand injury that disabled you for a week or longer (dislocation, sprain, etc.)? NO YES R or L

List injury/dates

Have you ever had wrist or hand surgery? NO YES R or L

What was done/why

Date(s)

Have you ever been told that you injured the patella, patella tendon, or front part of your knee?

NO YES R or L

List injury/dates

Have you ever been told that you injured the cartilage/meniscus in your knee? NO YES

R or L

List injury/dates

Have you ever been told that you injured the ligaments in your knee? NO YES R or L  
List injury/dates

Have you ever had knee surgery? NO YES R or L  
What was done/why Date(s)

Have you had an ankle injury that disabled you for a week or longer (sprain, strain, dislocation, etc.)? NO YES R or L  
List injury/dates

Have you ever had ankle surgery? NO YES R or L  
What was done/why Date(s)

Do you presently have a rod, pin, screw or plate anywhere in your body? NO YES  
Where? Date(s)

Do you wear contact lenses while participating in your sport? NO YES

Do you wear any removable dental appliance? NO YES  
(Circle those, which apply) REMOVABLE RETAINER  
REMOVABLE BRIDGE REMOVABLE PLATE

Are you missing one of a set of paired organs (kidneys, eyes, testicles)? NO YES  
Specify

Do you have any other conditions you wish to make us aware of? NO YES  
Specify and give details.

**PLEASE GIVE THE DATES OF YOUR LAST IMMUNIZATIONS FOR:**

Diphtheria	Tetanus	Measles	Influenza/Flu
Polio			
Rubella	Hepatitis A	Hepatitis B	
Mumps			

**FEMALE ATHLETES ONLY**

Are you pregnant, or do you suspect that you may be pregnant? NO YES  
(If the answer is “Yes”, this does not necessarily preclude sport participation; however,  
you must present clearance from a physician stating that sport participation will not be  
detrimental to the pregnancy.)

**DISABLED ATHLETES ONLY**

Please indicate your disability and how it occurred.  
What & When

**THE ABOVE QUESTIONS HAVE BEEN ANSWERED COMPLETELY AND  
TRUTHFULLY TO THE BEST OF MY KNOWLEDGE.**

Date

Signature