(Confidential)

Medical History Form

Past Injuries:

Do you have, or have you ever had, any of the following conditions? If so, Please check the blank and state the year:

INJURY DO YOU HAVE THIS INJURY NOW?

____ Concussion (s)(number ____________________
____ Skull fractures (s)(number)____________________
____ Neck injuries____________________
____ Shoulder injuries ____________________
____ Elbow injuries____________________
____ Arm/wrist/hand injuries____________________
____ Rib cage injuries ____________________
____ Back injuries____________________
____ Hip injuries ____________________
____ Thigh injuries ____________________
____ Knee injuries ____________________
____ Lower leg injuries/ "shin splints ____________________
____ Ankle injuries ____________________
____ Foot injuries ____________________
____ Muscle strains (pulls) ____________________
____ Any injury to any part not mentioned? ____________________
____ False teeth or bridge? ____________________
____ Ever had an arthroscopy? What joint?____________________
____ Ever been advised to restrict activity during the past 5 years? ____________________
____

Past Illness Or Medical Problems

Do you now have, or have you ever had, any of the following conditions? If so, please check the blank and state when:

____Surgical operations: ____________________
____Confinement to hospital ____________________
____Frequent headaches____________________
____Fainting spells, dizziness or weakness____________________
____Weakness or illness when exposed to high temperatures ____________________
____Epilepsy or convulsions ____________________
____Numbness or tingling ____________________
____Nosebleeds____________________
____Difficulty hearing ____________________
____Heart murmur ____________________
____Arthritis ____________________
____Diabetes (type) ____________________
____Any abnormal bleeding tendencies____________________
____Loss of, or serious impairment of, a paired organ (eg.,kidney, eye, lung) ____________________
____Osgood-Schlatter's disease of the knee____________________
____Hepatitis or jaundice ____________________
____Acquired immune deficiency syndrome (AIDS) ____________________
____Infectious mononucleosis (mono)____________________
Do you take medications regularly? List: ____________________
Anything not mentioned? ____________________
____

____________________ ____________________
Parent or Guardian Signature Date

02/26/08

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