



Appendix 1

## MEDICAL HISTORY QUESTIONNAIRE

### PLAYER INFORMATION:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_\_

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

Phone:(\_\_\_\_) \_\_\_\_\_

**PLEASE CIRCLE NO OR YES AND LIST DETAILS AS REQUESTED. ALL INFORMATION WILL REMAIN CONFIDENTIAL AND APPLIED ONLY TO EMERGENCY CARE SITUATIONS.**

**NO / YES** Do you have any allergies? (Foods, medications, etc.) Please list: \_\_\_\_\_  
\_\_\_\_\_

**NO / YES** Do you regularly take any over the counter and/or prescription medication? Please list and provide reasons: \_\_\_\_\_

**NO / YES** Have you ever been told that you have (had) asthma or exercise induced asthma?  
List medications: \_\_\_\_\_

**NO / YES** Have you ever been diagnosed with any major diseases or conditions? (diabetes, epilepsy, heart disease, etc.)  
List: \_\_\_\_\_

**NO / YES** Do you have or have you ever had a hernia or rupture? List dates if repaired: \_\_\_\_\_

**NO / YES** Have you ever been knocked out or had a concussion or other closed head injury?  
List dates: \_\_\_\_\_

**NO / YES** 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 L List injury/dates \_\_\_\_\_

**NO / YES** Have you ever injured the ligaments in your knee? **Right or Left**  
List injury/dates: \_\_\_\_\_

