General Medical History

Name:_________________________________ Date of Birth:__________________

Dates of most recent tetanus booster: __________

When reply is **YES** please give specific date and treatment if required:

PERSONAL HISTORY – Have you had?…

	Yes	No		Yes	No
Allergies to food			Frequent Headaches		
Allergies to medications			Tumor, Cancer, Cyst		
Currently taking medications			Weakness/Paralysis		
Diabetes			Bleeding disorder		
High/Low Blood Pressure			Frequent Nosebleeds		
Heart Disease			Stomach/Intestinal Trouble		
Rheumatic Fever/Heart Murmur			Recurrent Diarrhea/Constipation		
Pain/Pressure in Chest			Recent Weight Loss/Gain		
Palpatations (Heart)			Hepatitis		
Asthma			Organ Removed		
Hayfever			Hernia		
Pneumonia			Arthritis		
Hyperventilation			**FEMALES ONLY:**		
Shortness of Breath			Irregular Periods		
Heart Exhaustion/Heatstroke			Severe Cramps		
Mono			Medications Needed		

Please elaborate:____

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NON SPORTS RELATED – Give details below	**YES**	**NO**
Have you had any illness, injury, or hospitalization no already noted during the past 3 years?		
Has your physical activity been restricted during the past three years?		
Have you had any surgeries?		
Have you ever been advised NOT to participate in sports?		

Please elaborate:____

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(OVER)

When reply is **YES**, please give location of injury (right or left side), date of injury, and treatment.

	Yes	No		Yes	No
EYES – EARS – TEETH			**WRIST – HANDS – FINGERS –THUMB**		
Have you ever had to wear?…			Sprain?		
Contacts (circle one) SOFT or HARD			Dislocation		
Glasses			Surgery Complete (Date)		
Hearing Appliance			Comments		
Dental Appliance					
Permanent Bridge					
Permanent Crown/Jacket			**BACK-HIP**		
Removable Partial Plate			Injury to back (specify)		
Removable Full Plate			Medical Treatment Required		
Any Dead Teeth – Indicate Location			Back Pain – indicate frequency		
Comments					
			Very Seldom – Occasional – Frequent		
HEAD – NECK			Back pain that causes numbness		
Concussion past three years			tingling/weakness in buttocks/legs/toes		
Fainting, dizziness, vision problems			Hip Injury (specify)		
Stinger, Jammed Neck			Pinched Nerve, Whiplash	`	
Unconsciousness due to head injury			Surgery completed (date)		
Skull Fracture			Pin, Screw, Plate related to surgery		
Hospitalization due to head injury					
Comments:			Comments:		
SHOULDER – CHEST			**KNEE – LEG**		
Shoulder Dislocation/separation			Osgood-Schlatter Disease		
Chest/Abdominal Injury			Dislocation/Fracture (specify)		
Advised to have surgery (specify type)			Ligament/Cartilage Injury (specify)		
Surgery Completed (date)			Arthroscopic Exam		
Comments			Advised to have surgery(specify type)		
ELBOW – ARM			**ANKLE – FOOT – TOES**		
Severe sprain			Sprain (ankle, foot, toes, right or left)		
Dislocation/Fracture (specify)			Dislocation/Fracture		
Hyperextension			Tape or wear brace for sports		
Surgery Completed (date)			Foot/Arch Problems		
Comments			Surgery completed (date)		
			Comments		

Additional information or comments:_______________________________________