



Health History Questionnaire

NAME _____ SPORT _____
(Last) (First) (Middle)

SOCIAL SECURITY NUMBER _____ DATE _____

PARENT'S NAME _____

PARENT'S ADDRESS _____
(Street)

(City) (State) (Zip Code)

PARENT'S TELEPHONE NUMBER _____

PARENT'S CELL NUMBER _____

- | | <u>Circle</u> | |
|--|---------------|----|
| 1. Have you ever been hospitalized?
DATE:
WHERE:
WHAT FOR: | yes | no |
| 2. Have you ever had a major injury?
DATE:
BODY PARTS:
INJURY: | yes | no |
| 3. Have you had a tetanus booster in the last 10 years?
DATE: | yes | no |
| 4. Have you had any history of being knocked unconscious while playing sports or in other activity?
DATE:
WHERE:
CAUSE/TREATMENT: | yes | no |
| 5. Have you had any history of neck injuries?
DATE:
WHERE:
CAUSE/TREATMENT: | yes | no |
| 6. Have you any history of "burners", "stingers", numbness or weakness in neck, shoulder or hand?
DATE:
WHERE:
CAUSE/TREATMENT: | yes | no |
| 7. Have you any history of back pain or back injury?
DATE:
WHERE:
CAUSE/TREATMENT: | yes | no |
| Have you been diagnosed as having scoliosis? | yes | no |

- | | | | |
|-----|--|-----|----|
| 11. | Have you ever had an ankle injury? | yes | no |
| | a. Ligament sprain | yes | no |
| | R or L: | | |
| | LATERAL (outside) or MEDIAL (inside): | | |
| | DATE: | | |
| | CAUSE/TREATMENT: | | |
| | b. Achilles tendon injury | yes | no |
| | R or L: | | |
| | DATE: | | |
| | CAUSE/TREATMENT: | | |
| | c. Ankle or lower leg fracture | yes | no |
| | R or L: | | |
| | WHICH BONE: | | |
| | DATE: | | |
| | CAUSE/TREATMENT: | | |
| 12. | Have you ever had a foot injury? | yes | no |
| | R or L: | | |
| | DATE: | | |
| | CAUSE/TREATMENT: | | |
| 13. | Have you ever had a hip injury? | yes | no |
| | R or L: | | |
| | DATE: | | |
| | CAUSE/CIRCUMSTANCES: | | |
| 14. | Have you ever had an elbow, arm, wrist or hand injury? | yes | no |
| | R or L: | | |
| | DATE: | | |
| | CAUSES/TREATMENT: | | |
| 15. | Have you ever had an injury that required you to miss more than 3 days of practice (that is not noted above)? | yes | no |
| | TYPE: | | |
| | DATE: | | |
| | CAUSES/TREATMENT: | | |
| 16. | Have you ever required surgery for any medical-illness or any injury? . | yes | no |
| | DATE: | | |
| | BODY PART: | | |
| | CAUSE/TREATMENT: | | |
| 17. | Have you been found to have only one of the two (paired) functioning organs? (eyes, kidneys, testicle, ovary, etc) | yes | no |
| | WHICH ONE: | | |
| 18. | Do you require medication on a daily or episodic routine? (Daily insulin or asthma medication) | yes | no |
| | If SO, WHAT MEDICATION: | | |
| | WHAT CONDITION: | | |
| | TAKEN HOW OFTEN: | | |

