8170 S. University Blvd. Ste #190
Centennial, CO 80122
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Medical History Questionnaire

Please PRINT Clearly

Name _____
Last First Middle

Date of Birth _____ Sex _____

Address _____
Street City State Zip

Emergency Contact _____ Phone (_____) _____

Please circle "YES" or "NO" and provide additional details where requested on all three sides of this form.

1. Are you allergic to any medication (aspirin, penicillin, sulfa, etc.)?
NO YES (list) _____

2. Do you take any prescribed medication on a permanent or semi-permanent basis (steroids, anti-inflammatories, antibiotics, insulin, etc.)?
NO YES (list and give reason) _____

3. Have you ever had an epileptic seizure?
NO YES (date(s)_____

4. Have you ever been told by a doctor that you have epilepsy?
NO YES (list any medication) _____

5. Have you ever been treated for diabetes?
NO YES (list any medication) _____

6. Have you ever been told by a doctor that you were anemic?
NO YES (when?) _____ (what treatment?) _____

7. Have you ever been told by a doctor that you have sickle cell anemia?
NO YES (information we should know)_____

8. Do you have or have you ever had high blood pressure?
NO YES (list any medication) _____

9. Do you have, or have you ever had, the following diseases?
Heart disease (heart murmur, rheumatic fever, other)
NO YES (give name and date) _____

Lung disease (pneumonia, other)
NO YES (give name and date) _____

Kidney disease (infections, other)
NO YES (give name and date) _____

Liver disease (mononucleosis, hepatitis, other)
NO YES (give name and date) _____

10. Have you ever been told by a doctor that you have asthma?
NO YES (list any medication) _____

11. Do you have or have you ever had a hernia or “rupture”?
NO YES (if so, has it been repaired?) _____

12. Have you been “knocked out” or become unconscious in the past three years?
NO YES (if so, describe and give date(s) _____

13. Have you had a concussion or other head injury in the past three years?
NO YES (if so, describe and give date(s) _____

14. Have you stayed overnight in a hospital due to a head injury?
NO YES (if so, list date(s) _____

15. Have you ever had a neck injury involving bones, nerves, or disks that disabled you for a week or longer?
NO YES (type of injury?)_____ date(s) _____

16. Do you wear glasses or contacts during competition?
No YES (which?)_____

17. Do you wear any of the following dental appliances:
NO YES (Circle those that apply)

Permanent bridge	Braces	Removable retainer	Permanent retainer
Removable partial plate	Full plate	Permanent crown or jacket	

18. Have you had a broken bone (fracture) in the past two years?
NO YES (what bone?) _____ (right or left?) _____date(s)_____

19. Have you had a shoulder injury in the past two years that disabled you for a week or longer (dislocation, separation, etc.)?
NO YES (type of injury) _____(right or left?) _____ date(s) _____

20.Have you ever had shoulder surgery?
NO YES (what was done and why?)_____
(right or left?) _____ date(s) _____

21. Have you ever injured your back?
NO YES (type of injury?) _____ date(s)_____
22. Do you have back pain?
NO YES (Circle any that apply)
Seldom Occasionally Frequently With Vigorous Exercise With Heavy Lifting

23. Have you injured your knee in the past two years?
NO YES (what was done and why?)_____
(right or left?) _____ date(s) _____

24. Have you been told by a doctor or athletic trainer that you injured the cartilage in your knee?
NO YES (right or left?) _____ date(s) _____

25. Have you ever had knee surgery?
NO YES (what was done and why?) _____
(right or left?) _____ date(s) _____

27. Have you had a severe ankle sprain in the past two years?
NO YES (when and treatment?)_____

28. Do you have a pin, screw, or plate in your body?
NO YES (where in your body? _____ date(s) _____

29. Do you have any other conditions that we should be aware of (i.e., ulcers, pregnancy, food or insect allergies, tendonitis, etc.)?
NO YES (specify and give details) _____

30. Please give the dates of your last tetanus and polio shots:
Tetanus: _____ Polio: _____

The questions on this form have been answered completely and truthfully to the best of my knowledge.

Print Name _____

Signature _____ Date _____

Parent/Guardian Signature_____

(If participant is under 18)