____
Players Name

Medical History

Player must answer every question by checking YES or NO. Yes answers require that you fully explain in comment section.

HAVE YOU EVER HAD or DO YOU HAVE…?

YES	NO	COMMENT (GIVE DATES)
		Ongoing or Chronic Illness:
		Surgery:
		Hepatitis:
		Diabetes:
		Rheumatic Fever:
		Heart Disease:
		Kidney Problems:
		Asthma:
		Epilepsy:
		Sickle Cell Anemia:
		Appendicitis:
		Hernia:
		Frequent Headaches:
		Concussion:
		Frequent Nosebleeds:
		Dizziness:
		Collapsed Lung:
		Chest Pain:
		Shortness of Breath:
		Irregular Heart beat:
		Heart Murmur:
		High Blood Pressure:
		Stomach Ulcer:
		Mononucleosis:
		Intestinal Disorder:
		Venereal Disease:
		Hives, Rash:
		Skin Infection:
		Loss of Consciousness:
		Cancer:
		Taking Prescription Medications:
		Taking Over Counter Medications:
		Allergic to Medications:
		Allergic to Foods, Insects, Pollen:
		Numbness of Hands or Feet:
		Heat Illness/ Heat Stroke:
		Eye Injury or Problems:
		Wear Glasses:
		Wear Contacts:
		Use Tobacco/ How Much:
		Use Alcohol/ How Much:
		Wearing Hearing Aids:
		Wear Knee or Ankle Brace:
		Excessive Bleeding After Dental Extraction:

Please answer the following questions:

Has any family member died of heart problems or of sudden death before the age of 50? ☐ Yes ☐ No

Immunization Dates: Tetanus ________ Hepatitis B ________ Measles________ Chicken Pox________

Have you ever or are you now taking or using narcotics, marijuana, or illegal drugs? ☐ Yes ☐ No