STERLING'S
TEAM SPEED
THE TRAINING STARTS HERE

Medical History Questionnaire

Full Name _____ DOB _____ Gender _____

Address _____
Street City State Zip

Emergency Contact _____ Phone (_____) _____

Please check "YES" or "NO" and provide additional details where requested on all pages of this form.

	YES	NO
1. Are you allergic to any medication (aspirin, penicillin, sulfa, etc.)? *If yes, please list:*		
2. Do you take any prescribed medication on a permanent or semi-permanent basis (steroids, anti-inflammatories, antibiotics, insulin, etc.)? *If yes, please list and give reason:*		
3. Have you ever had an epileptic seizure? *If yes, please provide date(s):*		
4. Have you ever been told by a doctor that you have epilepsy? *If yes, please list medications:*		
5. Have you ever been treated for diabetes? *If yes, please list medications:*		
6. Have you ever been told by a doctor that you were anemic? *If yes, when and what treatment(s) were you given/prescribed?*		

7. Have you ever been told by a doctor that you have sickle cell anemia? *If yes, please note any information we should know:*		
8. Do you have or have you ever had high blood pressure? *If yes, please list medications:*		
9. Do you have, or have you ever had, the following diseases: **Heart disease (heart murmur, rheumatic fever, other)**? *If yes, please provide diagnosis and date:*		
10. Do you have, or have you ever had, the following diseases: **Lung disease (pneumonia, other)**? *If yes, please provide diagnosis and date:*		
11. Do you have, or have you ever had, the following diseases: **Kidney disease (infections, other)**? *If yes, please provide diagnosis and date:*		
12. Do you have, or have you ever had, the following diseases: **Liver disease (mononucleosis, hepatitis, other)**? *If yes, please provide diagnosis and date:*		
13. Have you ever been told by a doctor that you have asthma? *If yes, please list medications:*		
14. Do you have or have you ever had a hernia or "rupture"? *If yes, has it since been repaired?*		
15. Have you been "knocked out" or become unconscious in the past three years? *If yes, please describe and provide dates:*		
16. Have you had a concussion or other head injury in the past three years? *If yes, please describe and provide dates:*		

17. Have you stayed overnight in a hospital due to a head injury? *If yes, please list dates:*		
18. Have you ever had a neck injury involving bones, nerves, or disks that disabled you for a week or longer? *If yes, please describe the type of injury and dates:*		
19. Do you wear glasses or contacts during competition? *If yes, which?*		
20. Do you wear any of the following dental appliances: **Permanent bridge, braces, removable retainer, permanent retainer, removable partial plate, full plate, permanent crown or jacket**? *If yes, which?*		
21. Have you had a broken bone (fracture) in the past two years? *If yes, please provide the bone(s) and date(s):*		
22. Have you had a shoulder injury in the past two years that disabled you for a week or longer (dislocation, separation, etc.)? *If yes, please provide the type of injury, side, and date(s):*		
23. Have you ever had shoulder surgery? *If yes, please describe what was done, when, and why:*		
24. Have you ever injured your back? *If yes, please provide the type of injury and date(s):*		
25. Do you have back pain? *If yes, please select all that apply:* Seldom Occasionally Frequently With vigorous exercise With heavy lifting		
26. Have you injured your knee in the past two years? *If yes, please describe what was done, when, and why:*		
27. Have you been told by a doctor or athletic trainer that you injured the		

cartilage in your knee? *If yes, which side, and what date(s):* Right Left Date(s):		
28. Have you ever had knee surgery? *If yes, please describe what was done, when, and why?*		
29. Have you had a severe ankle sprain in the past two years? *If yes, please provide the date(s) and treatment(s):*		
30. Do you have a pin, screw, or plate in your body? *If yes, please describe the location(s) in your body and date(s):*		
31. Is there anything else pertaining to your health that we should be aware of (i.e., ulcers, pregnancy, food or insect allergies, tendonitis, etc.)? *If yes, please specify and provide details:*		
32. Are your tetanus and polio vaccinations up to date? *If yes, please provide the dates of your last shots:* Tetanus: Polio:		

Your signature below indicates that all questions on this form have been answered completely and truthfully to the best of your knowledge.

Print Name _____

Signature _____ Date _____

Parent/Guardian Name _____ *(If participant is under 18)*

Parent/Guardian Signature_____ *(If participant is under 18)*