General Medical History and Injury Inquiry

Name:_____ Today's Date:_____

Please check any of the following for injuries, surgeries or health problems that you have had or currently have. If you answer "yes" to any of the listed injuries please explain each injury in detail and when the injury occurred.

1) Concussion or Head Injury/Surgery, When? YES_____ NO____

_____

2) Shoulder Injury/Surgery, When? YES____ NO____

_____

3) Elbow or Wrist Injury, When? YES____ NO____

_____

4) Hand or Finger Injury/Surgery, When? YES____ NO____

_____

5) Hip or Back Injury/Surgery, When? YES____ NO____

_____

6) Knee or Ankle Injury/Surgery, When? YES____ NO____

_____

7) Sickle Cell Trait, Diabetes, ADD & ADHD? YES____ NO____

_____

Athlete's Name: _____

Parent's Name: _____