San Diego Swish Pro-Am Basketball League

Medical History

Date: _____

Name: _____

Address: _____

City/St/Zip: _____

Phone #: _____

Date of Birth: _____

Date of last physical exam by a doctor:

_____

Date of last tetanus booster: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS.

GIVE DETAILS AT THE EXPLAIN AREAS TO ALL "YES" ANSWERS:

	YES	NO
a. Have you been under a doctor's care in the last 12 months?	( )	( )
b. Have you been in the hospital in the last 12 months?	( )	( )
c. Have you had any type of surgery?	( )	( )
d. Are you currently dealing with a health problem?	( )	( )
e. Has anyone in you family, died suddenly? (under age of 50)	( )	( )

Explain: _____

	YES	NO
f. Have you ever had or now have?		
Concussion (head injury)	( )	( )
Skull Fracture	( )	( )
Convulsion or epilepsy	( )	( )
Neck Injury	( )	( )
Stinger, burner, pinched nerve	( )	( )

Explain all "yes" answers:_____

_____

	YES	NO
g. Are you allergic to :		
Penicillin	( )	( )
Other medications	( )	( )
Any foods	( )	( )
Other substances	( )	( )

Explain all "yes" answers: _____

_____

	YES	NO
h. Have you ever or do you now have:		
Hay Fever	( )	( )
Exercised Induced Asthma	( )	( )
Asthma	( )	( )
Allergies to bites/stings	( )	( )
Do you need an Epi Pen	( )	( )
Do you need an inhaler	( )	( )
i. Have you had or do you now have:		
High blood pressure	( )	( )
Heart trouble/murmur	( )	( )
Persistent cough	( )	( )
Tendency to faint	( )	( )
Dizzy/Faint with exercise	( )	( )
Chest pain/discomfort w/ exercise	( )	( )
j. Have you ever had an EKG?	( )	( )

Explain: _____

	YES	NO
k. Have you ever been told to give up sports due to health problems?	( )	( )

Explain: _____

_____

For the following questions, be as SPECIFIC as possible. Detail what happened, when it happened, right or left side, casted or immobilized, how long, rehabilitation, doctor's name/city.

YES NO 1. Have you had a finger, hand or wrist injury?
_____

YES NO 2. Have you had a sprain, dislocation, fracture, or other injury to forearm or elbow?
_____

YES NO 3. Have you had a shoulder dislocation, separation, or other injury?
_____

YES NO 4. Have you had an injury to your hip or pelvis area?
_____

YES NO 5. Have you had knee surgery? What other injuries have you had to your knees?
_____

YES NO 6. Have you experienced a severe ankle sprain or injury to your foot or ankle?
_____

YES NO 7. Have you had an injury to your upper or lower back?
_____

YES NO 8. Do you experience pain in your back?
_____

YES NO 9. Do you wear orthodics in your shoes? Why? Who prescribed them and when?
_____

YES NO 10. Have you had any problems with muscle strains or pulls?
_____

YES NO 11. Have you had any other significant injuries?
_____

YES NO 12. Have you had any other operations in the past 5 years? Explain in detail:
_____

YES NO 13. Are you currently on prescribed medication? Indicate drug prescribed & dosage:
_____

YES NO 14. Are you currently under the care of a physician? Reason for care?
_____

I HAVE READ AND ANSWERED ALL OF THE ABOVE QUESTIONS COMPLETELY AND TRUTHFULLY TO THE BEST OF MY KNOWLEDGE.

_____ _____

Athlete's Name printed & Signature Date

_____ _____

Parent/Legal Guardian (Under 18) Printed name & Signature Date

_____ _____

ATC Reviewed Sign & Print Date