

Medical History Questionnaire

Name _____
Date of Birth _____
Sport & Level _____
Sex _____ Weight _____ Height _____
Address _____
City _____ State _____ Zip _____
E-mail Address _____
Parent(s)names _____
Emergency Contact _____ Phone _____

Please circle "Yes" and "No" and provide additional details where requested on both sides of this form. All information will be confidential.

General Medical History

- 1. Do you have a chronic illness? NO YES
2. Have you ever been hospitalized? NO YES (Dates)
3. Have you ever had surgery? NO YES (Type, Date)
4. Do you have any organs missing? NO YES
5. Have you ever been disqualified from participation? NO YES
6. What was the date of your last tetanus injection?
7. Do you take any prescribed medication on a permanent or semi-permanent basis (steroids, birth control pills, anti-inflammatory agents, antibiotics, etc.)? NO YES (list with reason)
8. Do you wear glasses or contact lenses during competition? NO YES
9. Do you wear any of the following dental appliances: BRACES PERMANENT BRIDGE REMOVABLE RETAINER PERMANENT RETAINER REMOVABLE PARTIAL PLATE FULL PLATE PERMANENT CROWN OR JACKET NO YES (Circle those which apply)

Past Medical History

- 10. Have you ever been knocked out or had a concussion? NO YES (Dates)
11. Have you ever been hospitalized because of a head injury? NO YES (Dates)
12. Do you have epilepsy (seizure disorder)? NO YES (list medication)
13. Do you have asthma? NO YES (list medication)
14. Do you have lung disease (e.g. pneumonia)? NO YES (Date)
15. Has any family member had sudden death or heart attack before age 50? NO YES
16. Have you had any heart disease, murmur, extra heart beats, or high blood pressure? NO YES (particulars, dates)

- (list medications)
17. Have you ever been dizzy or passed out from exercise?
 NO YES (Dates)
18. Do you have (or ever had) anemia?
 NO YES (type and dates)
19. Do you have sickle cell anemia (or trait)?
 NO YES
20. Do you have sugar diabetes?
 NO YES (list medication)
21. Do you have any menstrual irregularities?
 NO YES (describe)
22. Do you have frequent vomiting?
 NO YES (dates)
23. Are you on a special diet?
 NO YES (type)
24. Do you have any medication allergies?
 NO YES (type)
25. Do you have any environmental allergies?
 NO YES (type)
26. Do you have any allergies to insect stings or bites?
 NO YES (type)
27. Are you currently taking any prescription medications?
 NO YES (name, dose)
28. Are you currently taking any over-the-counter medications?
 NO YES (name, dose)
29. Do you have any other conditions that we should be aware of?
 NO YES (details)
- _____
- _____
- _____
- _____
- _____

Orthopedic History

30. Do you or have you ever had a hernia ("rupture")?
 NO YES Has it been repaired?
31. Have you ever had a neck injury involving bones, nerves, or discs disable
 for a week or longer? Describe.
32. Have you had a broken bone or fracture in the past 2 years?
 NO YES R or L _____ What Bone?
 Dates _____
33. Have you had a shoulder injury in the past 2 years that disabled you for a
 week or longer (dislocation, separation, etc.)?
 NO YES R or L _____ Type of injury
 Dates _____
34. Have you ever had shoulder surgery?
 NO YES R or L _____ Type and reason
 Dates _____
35. Have you ever had hand or wrist injuries?
 NO YES R or L _____ Type of injury
 Dates _____

36. Do you have back pain?
 NO YES (Circle those which apply)
 SELDOM OCCASIONALLY FREQUENTLY WITH VIGOROUS EXERCISE
 WITH HEAVY LIFTING
37. Have you ever injured your back?
 NO YES Type of injury
 Dates _____
38. Have you injured your hip in the past 2 years?
 NO YES Type of injury
 Dates _____
39. Have you injured your knee in the past 2 years?
 NO YES R or L Type of injury
 Dates _____
40. Have you ever had knee surgery?
 NO YES R or L Type
 Dates _____
41. Have you had a severe ankle sprain in the past 2 years?
 NO YES R or L Type
 Dates _____
42. Do you have a pin, screw, or plate in your body?
 NO YES Where?
 Dates _____
43. What over the counter medications is your child allowed to take (and what dosage)?

THE QUESTIONS ON THIS FORM HAVE BEEN ANSWERED COMPLETELY AND TRUTHFULLY TO THE BEST OF MY KNOWLEDGE.

 Signature of Skater

 Date

INSURANCE FORM

Name of Skater:

Parent's Name:

Insured's Name:

Relationship to Patient:

Name of Insurance:

Is this a group or individual policy ?

Employer's Name:

Employee I.D. # _____

Group Account # _____

Benefit Code Insurance:

Name and Address for billing:

Does Ins. require pre-certification or second surgical opinion ?

Insurance phone:
