Medical Questionnaire

Name:_____ **Sport/Position:**_____

Date of Birth: _____

1. **Have you ever had an injury that caused you to miss more than two weeks of participation?** _____ **Yes** _____ **No**
   a. **Explain/Approximate Date(s)**

2. **Have you ever had any surgery?** _____ **Yes** _____ **No**
   a. **What kind of surgery and when?**

3. **Have you ever broken any bones?** _____ **Yes** _____ **No**
   a. **Which ones and when?**

4. **Have you ever sustained a concussion?** _____ **Yes** _____ **No**
   a. **How many?** _____
   b. **When was the last one?** _____
   c. **How long until you returned to activity?** _____

5. **Have you ever been told you have any kind of heart problem?** _____ **Yes** _____ **No**
   a. **Explain**

6. **Have you ever been told you have high blood pressure?** _____ **Yes** _____ **No**
7. **Have you ever been told you have sickle cell trait?** _____ **Yes** _____ **No**
8. **Do you have any other medical conditions? (asthma, diabetes, etc.)** _____ **Yes** _____ **No**
   a. **Explain**

9. **Do you have any allergies? (food, medical, seasonal, etc.)** _____ **Yes** _____ **No**
   a. **Explain**

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10. Please list any Daily Medicines:

11. Do you have medical insurance? _____ **Yes** _____ **No**

If YES Please email a copy of the front and back of your Insurance Card to szavala@fca.org.

Medical Insurance Carrier _____

Policy Number _____

Primary Physician Name _____

Primary Physician Number _____

The information I have provided is true and accurate to my knowledge.

_____ _____

Participant **Date**

_____ _____

Parent/Guardian if under 18 **Date**