

MEDICAL HISTORY FORM
2019 - 2020 SEASON - PLEASE PRINT

Wrestler's Name: _____

PLEASE CIRCLE THE CORRECT ANSWER. ALL INFORMATION WILL BE CONFIDENTIAL

- Yes No 1. Are you allergic to any general medications (aspirin, sulfa, penicillin, etc)? If yes, please indicate which medication(s): _____
- A. Other allergies: _____
- Yes No 2. Have you ever been informed by a medical doctor that you have asthma? If so, what medications, if any, do you take regularly? _____
- Yes No 3. Have you ever had an epileptic seizure or been informed that you might have epilepsy?
- Yes No 4. Have you ever been treated for diabetes? If so, please indicate the type(s) of insulin or pills you use: _____
- Yes No 5. Has a medical doctor ever told you that you were anemic or had sickle cell anemia?
- Yes No 6. Do you have high blood pressure? If so list any medications for it that you take regularly: _____
- Yes No 7. Are you on any other prescribed medication on a permanent or semi-permanent basis? If so, please indicate the name of the medication and why it was prescribed: _____
- Yes No 8. Do you have or have you ever had any of the following diseases? If so please circle the appropriate ones:
- | | |
|---------------------------------|---------------------------|
| Heart disease (rheumatic fever) | Liver disease (hepatitis) |
| Kidney disease (infections) | Lung disease (pneumonia) |
- Yes No 9. Do you presently have an unrepaired hernia?
- Yes No 10. Have you ever been "knocked out" or experienced a concussion during the past 3 years? If so, give the dates of each: _____
- Yes No 11. If the answer to No. 10 is "yes" did the attending physician have you stay overnight in a hospital? If yes, give the dates of each: _____
- Yes No 12. Have you ever had an injury to your neck involving nerves, vertebrae (bones), or discs that incapacitated you for a week or longer? If so, please give the dates of each: _____
- Yes No 13. Do you wear any dental appliance? If yes, circle the appropriate appliance:
- | | |
|--------------------|---|
| Permanent bridge | Permanent crown or jacket |
| Braces | Full plate Removable partial plate |
| Permanent Retainer | Removable Retainer |
- Yes No 14. Do you wear contact lenses during competition?

PLEASE CONTINUE THIS FORM TO THE NEXT PAGE. THANK YOU.

MEDICAL HISTORY FORM – 2019-2020 SEASON - continued

Wrestler's Name: _____

Yes No 15. Have you had a fracture during the past 2 years? If yes, indicate which bone was broken and the date it happened: _____

Yes No 16. Have you had a shoulder dislocation, separation or other shoulder injury in the past 2 years that incapacitated you for a week or longer? If so give the date of the injury: _____

Yes No 17. Have you ever had surgery to correct a shoulder condition? If so, please indicate the dates and the procedure(s): _____

Yes No 18. Do you experience pain in your back? If yes, indicate frequency:

Seldom
With vigorous Exercise

Occasionally
With heavy lifting

Frequently

Yes No 19. Have you injured your knee during the past 2 years with severe swelling as a result?

Yes No 20. Have you ever been told that you injured the ligaments and/or cartilage of either knee?

Yes No 21. Have you ever been advised to have surgery to correct a knee problem?

Yes No 22. If the answer to #21 is yes, has the surgery been completed? Date: _____

Yes No 23. Have you experienced a severe sprain of either ankle during the past 2 years?

Yes No 24. Have you had an injury to your foot or toes in the past 2 years? If yes, explain: _____

Yes No 25. Do you have any chronic skin conditions such as eczema? If so, explain: _____

Yes No 26. Do you have any chronic conditions that have not been mentioned above? If so, explain: _____

Year of your child's last complete physical examination by a medical doctor: _____

The questions on both sides of this form have been answered completely and truthfully to the best of my knowledge.

Parent/Guardian Signature: _____ Date: _____