REVIEW OF INJURIES Name_________________________

	YES	NO	Explain All Yes Answers
Have you ever had an injury that caused limitation of activity or required medical attention?			
Have you ever been casted, splinted or used a cane, sling or crutches?			
Have you required special taping, wrapping or bracing for participation in sports?			
Are you currently suffering from an injury?			
Have you ever had a head injury resulting in unconsciousness or any other symptoms? If yes, how many times and dates of each occurrence. Were you hospitalized? Have you had any problems since that time?			
Have you had dizzy spells, recurrent headaches, light headedness or memory loss from a head injury?			
Have you had rib cage pain?			
Do you have a chronic cough, recurrent colds or shortness of breath?			
Does exercise cause you to cough or become short of breath?			
Have you ever had an injury to your abdominal area or to any internal organ?			
Do you have recurrent abdominal cramping or pain?			
Do you have a hernia?			
Do you have pelvic or groin pain? If yes, how many times and dates?			
Do you have neck pain or pain into your shoulder or down your arms?			
Do you have an injury that causes any intermittent pain or problems?			
Do you wear orthotics or arch supports?			
Do you have any worries about your health or any other questions that you would like to discuss?			

Date of last dental exam ____________________ Date of last eye exam ______________________

Do you wear glasses? ________________________________ Contact lenses? ______________________

Do you have a medical condition that requires the use of prescription drugs?
(i.e. allergies, diabetes) Yes_________ No_________

If yes, what is the condition?____
What drug?____
How often is it taken?____

Do you use any over-the-counter supplements or medications?
Yes________________ No__________________

If yes, please list:____

** **Over-the-counter supplements and medications are legal, but may be banned by NCAA.**