FILETS Soccer Camp 2015
MEDICAL HISTORY FORM
Please complete and email it to filetsports@gmail.com

PERSONAL INFORMATION

Last Name _____ First Name _____Gender_____

Date of Birth _____Address _____ City _____

State _____ Zip Code _____ Phone_____

number_____Email_____

Institution

Street_____City_____

Country_____ Phone_____ Email_____

Sport: * Soccer, Basketball; Volleyball, Tennis

_____ _____

□ Have you participated in any soccer academy? □ Yes □ NO

In the case of Emergency
Parent or Guardian to be contacted

Name: _____ Relationship_____

Primary Phone Number_____ Cell Phone_____
Number_____

MEDICAL HISTORY

Have you ever had any of the following medical conditions? (Check all that apply)

	Yes	No		Yes	No		Yes	No
Abnormal Bruising			Elevated Cholesterol			Mononucleosis (MONO)		
Abnormal Bleeding			Gastrointestinal Bleed			Mumps		
Air or Car Sickness			Goiter, Thyroid Disease			Muscular Disease		
Anemia			Headaches (Frequent)			Nervous Stomach		
Appendicitis			Hearing Defect/Loss			Nose Fracture		
Arthritis			Heart Trouble/Murmur			Pneumonia		
Asthma			Hemorrhoids			Respiratory Infections		
Birth Defects			Hepatitis			Ruptured Organs		

Bladder Infections			Hernia			Seizures/Epilepsy		
Blood in Urine			Herpes (Genital)			Sickle Cell Anemia/Trait		
Blood Disease			Herpes (Oral)			Shingles		
Blood Clots			High Blood Pressure			Skin Disorders		
Bronchitis			HIV/AIDS			Tuberculosis		
Cancer			Joint Inflammations			Tumor, Growth, Cyst		
Chicken Pox			Kidney Problems			Ulcer		
Concussion			Loss of Memory			Urinary Infections (UTI)		
Constipation (Frequent)			Measles					
Diabetes			Meningitis			Other		
Eating Disorder			Migraine Headaches					

Do you currently have any of the following symptoms or problems?

□ If you answer yes to any of the above, please write the respective date and Information regarding the condition.

_____

_____

HEAT

Have you experienced any of the following

Trouble with dehydration: □ Yes □ No

Heat Stroke : □ Yes □ No

Heat Cramps : □ Yes □ No

Heat Intolerance : □ Yes □ No

ALLERGIES

□ Are you allergic to anything? □ No or □ If yes_____

CARDIAC

Have you ever…	Yes	No
Felt dizzy, light-headed or passed out during or after exercise?		
Had chest pain while exercising?		
Had an irregular heart beat or heart palpitations?		
Been told you have a heart murmur?		
Seen by a heart specialist (cardiologist)? If yes, Who: Date:		
Had an echocardiogram or EKG?		
Had a heart stress test?		

MEDICATIONS

Are you currently taking any medications?

□ Yes □ No if yes_____

CONCUSSION HISTORY

Have you ever sustained an injury to the head/face?

□ Yes □ No

Have you ever experienced any of the following symptoms after head/ face trauma?

	YES	NO		YES	NO
Unconscious			Slowed reaction time		
Dazed/dizzy			Memory problems		
Knocked out			Concentration problems		
Headaches			Irritability		
Loss of consciousness			Feeling sluggish, foggy or groggy		
Balance problems			Vomiting		
Double or fuzzy vision			Nausea		
Sensitivity to light			Sensitivity to noise		

Have you ever been removed from athletic participation because of a head injury?

□ Yes □ No

Have you ever been diagnosed as having a concussion?

□ Yes □ No

ORTHOPAEDIC HISTORY

HEAD/FACE

Laceration	YES ☐	NO ☐	Nose Bleed	YES ☐	NO ☐
Abrasion	YES ☐	NO ☐	Ear Injury	YES ☐	NO ☐
Contusion	YES ☐	NO ☐	Eye Injury	YES ☐	NO ☐
Headaches	YES ☐	NO ☐	Jaw Injury	YES ☐	NO ☐
Fracture	YES ☐	NO ☐	Mouth (lip/tongue) Injury	YES ☐	NO ☐

CERVICAL SPINE/NECK

	Sprain/Strain	NO ☐	Disk Injury	YES ☐	NO ☐
"Stiff Neck"	YES ☐	NO ☐	Dislocation	YES ☐	NO ☐
Fracture	YES ☐	NO ☐	Burners/Stinger	YES ☐	NO ☐

CHEST WAL

Sprain/Strain	YES ☐	NO ☐	Fractured Sternum	YES ☐	NO ☐
Fractured Collar Bone	YES ☐	NO ☐	Sterno-Clavicular Separation	YES ☐	NO ☐
Fractured Ribs	YES ☐	NO ☐	Contusion	YES ☐	NO ☐

SHOULDERS

Sprain/Strain	YES ☐	NO ☐	Acromio-Clavicular Separation	YES ☐	NO ☐
Subluxation	YES ☐	NO ☐	Arm "Goes Dead"	YES ☐	NO ☐
Dislocation	YES ☐	NO ☐	Pain w/ Overhead Activities	YES ☐	NO ☐
Tendonitis	YES ☐	NO ☐	Shoulder Slips Out of Place	YES ☐	NO ☐
Bursitis	YES ☐	NO ☐	"Winging" Scapulae	YES ☐	NO ☐
Impingement	YES ☐	NO ☐	Labral Tear	YES ☐	NO ☐
Stiff Shoulder	YES ☐	NO ☐	Rotator Cuff Tear	YES ☐	NO ☐

UPPER ARM/FOREARM

Sprain/Strain	YES ☐	NO ☐	Contusion	YES ☐	NO ☐
Numbness	YES ☐	NO ☐	Fracture	YES ☐	NO ☐
Tendonitis	YES ☐	NO ☐	General or Referred Pain	YES ☐	NO ☐

ELBOWS

Sprain/Strain	YES ☐	NO ☐	Contusion	YES ☐	NO ☐
Bursitis	YES ☐	NO ☐	Joint Locking	YES ☐	NO ☐
Dislocation	YES ☐	NO ☐	Bone Spur	YES ☐	NO ☐
Fracture	YES ☐	NO ☐	Tendonitis	YES ☐	NO ☐
Tingling/Numbness	YES ☐	NO ☐	Abrasion	YES ☐	NO ☐

WRISTS

Sprain/Strain	YES ☐	NO ☐	Contusion	YES ☐	NO ☐
Carpal Tunnel Syndrome	YES ☐	NO ☐	Cysts	YES ☐	NO ☐
Dislocation	YES ☐	NO ☐	Bone Spur	YES ☐	NO ☐
Fracture	YES ☐	NO ☐	Tendonitis	YES ☐	NO ☐
General Weakness	YES ☐	NO ☐	Snapping Wrist	YES ☐	NO ☐

HANDS/FINGERS

Sprain/Strain	YES ☐	NO ☐	Contusion	YES ☐	NO ☐
Carpal Tunnel Syndrome	YES ☐	NO ☐	Cysts	YES ☐	NO ☐
Dislocation	YES ☐	NO ☐	Bone Spur	YES ☐	NO ☐
Fracture	YES ☐	NO ☐	Tendonitis	YES ☐	NO ☐
General Weakness	YES ☐	NO ☐	Snapping Wrist	YES ☐	NO ☐

LOWER BACK

Sprain/Strain	YES ☐	NO ☐	Pinched Nerve/Pinching	YES ☐	NO ☐
Low Back Pain	YES ☐	NO ☐	Pain Down Leg	YES ☐	NO ☐
Disk Injury	YES ☐	NO ☐	Numbness in Leg	YES ☐	NO ☐
Fracture	YES ☐	NO ☐	Weakness in Leg	YES ☐	NO ☐

CORE/ABDOMINALS

Strain/Sprain	YES ☐	NO ☐	Cramping	YES ☐	NO ☐
Sports Hernia	YES ☐	NO ☐	Contusion	YES ☐	NO ☐
Abrasion	YES ☐	NO ☐	Laceration	YES ☐	NO ☐

Pelvis/HIPS

Sprain/Strain	YES ☐	NO ☐	Groin Pull	YES ☐	NO ☐
Fracture	YES ☐	NO ☐	Hip Pointer	YES ☐	NO ☐
Dislocation	YES ☐	NO ☐	Labrum Tear	YES ☐	NO ☐
Bursitis	YES ☐	NO ☐	Hernia	YES ☐	NO ☐
Bruised Tailbone	YES ☐	NO ☐	Contusion	YES ☐	NO ☐
Tingling/Numbness	YES ☐	NO ☐	Snapping Hip	YES ☐	NO ☐

THIGHS

Sprain/Strain	YES ☐	NO ☐	Contusion	YES ☐	NO ☐
Fracture	YES ☐	NO ☐	Tensor Fascia Latae Weakness	YES ☐	NO ☐
“Charlie Horse”	YES ☐	NO ☐	Tendonitis	YES ☐	NO ☐

Bursitis	YES ☐	NO ☐			

KNEES

Sprain/Strain	YES ☐	NO ☐	Patellar Fracture	YES ☐	NO ☐
Torn Ligaments	YES ☐	NO ☐	Patellar Grinding	YES ☐	NO ☐
Torn Cartilage	YES ☐	NO ☐	Patellar Subluxation	YES ☐	NO ☐
Torn Meniscus	YES ☐	NO ☐	Knee Locking	YES ☐	NO ☐
Tendonitis	YES ☐	NO ☐	Knee "Giving Way/Out"	YES ☐	NO ☐
Bursitis	YES ☐	NO ☐	Pain w/ Stairs	YES ☐	NO ☐
Chondromalacia	YES ☐	NO ☐	Jumper's Knee	YES ☐	NO ☐
Osgood's Schlatter's	YES ☐	NO ☐	IT Band Syndrome	YES ☐	NO ☐
Fracture/Microfracture	YES ☐	NO ☐	Osteoarthritis	YES ☐	NO ☐

Lower LEG

Sprain/Strain	YES ☐	NO ☐	Contusion	YES ☐	NO ☐
Shin Splints	YES ☐	NO ☐	Tingling/Numbness	YES ☐	NO ☐
Stress Fracture	YES ☐	NO ☐	Painful/Tight Calf w/ Activity	YES ☐	NO ☐
Fracture	YES ☐	NO ☐	Calf Cramping	YES ☐	NO ☐

ANKLES

Sprain/Strain	YES ☐	NO ☐	Ankle "Giving Out"	YES ☐	NO ☐
Tendonitis	YES ☐	NO ☐	Snapping Tendon	YES ☐	NO ☐
Dislocation	YES ☐	NO ☐	General Weakness	YES ☐	NO ☐
Fracture	YES ☐	NO ☐	Achilles Tendon Rupture	YES ☐	NO ☐
Syndesmodic/High Ankle Sprain	YES ☐	NO ☐	Tingling/Numbness	YES ☐	NO ☐

FEET/TOES

Sprain/Strain	YES ☐	NO ☐	Turf Toe	YES ☐	NO ☐
Tendonitis	YES ☐	NO ☐	Plantar Fascitis	YES ☐	NO ☐
Dislocation	YES ☐	NO ☐	Fallen Arches	YES ☐	NO ☐
Fracture	YES ☐	NO ☐	Orthodics	YES ☐	NO ☐
Stress Fracture	YES ☐	NO ☐	Contusion	YES ☐	NO ☐
Heel Spur	YES ☐	NO ☐	Sesmoiditis	YES ☐	NO ☐
Morton's Neuroma	YES ☐	NO ☐	Tingling/Numbness	YES ☐	NO ☐

Please check any and all diagnostic tests performed for any of the above upper or lower extremities

X-Rays ☐ MRI ☐ CT Scan ☐ Neurological Testing ☐ Bone Scan/Density ☐ Other ☐_____

Have you ever been hospitalized for any of the above injuries?

□ Yes or □ No if yes, please provide dates_____

Surgical Procedures

Please provide a list of all surgical procedures done with respective dates and pertinent information regarding injury.

Date (mm/yyyy)	R/L	Body Part	Surgical Procedure	Physician	Hospital/Surgical Center

Medical Attention

	Yes	No
Do you CURRENTLY have any medical problems or injuries?		

Are you CURRENTLY receiving medical treatment (physician, physical therapist, chiropractor, etc):			
If yes, provide name and phone number:	Physician:	Phone:	
Is there any reason that you are not able to participate in athletics?			
Has a doctor ever advised you not to participate in athletics?			
Do you wish to discuss any condition or problem with a physician, athletic trainer or counselor?			

If you answered YES to any of the above 5 questions, please explain below:

Medical Consent

I,_____, consent to medical treatment for athletic related injuries/illnesses by the FILETS Soccer Camp Sports Medicine Staff or Team Physician(s). I authorize treatment by such personnel in the event of any athletic related injury/illness.

Athlete Signature _____ Date _____

As a parent or legal guardian of _____, who is under the age of 18, I hereby authorize medical treatment of him/her in the event of an athletic related injury/illness by the FILETS Sports Medicine Staff or Team Physician(s).

Parent/Guardian Signature _____ Date _____

MEDICAL CARE STATEMENT

The undersigned,

A. Understands that any medical expense incurred due to the above pre-existing conditions is their personal responsibility.

B. Understands that it is his/her responsibility to report all injuries/illnesses to the medical team as soon as possible.

C. Understands that he or she must refrain from practice while ill or injured, as per athletic trainer or physician until he/she is discharged from treatment or is given permission to return to participation by the attending athletic trainer or physician.

D. Understands that having passed a physical examination does not necessarily mean that he/she is physically qualified to engage in athletics, but only the evaluator did not find a medical reason to disqualify him/her at the time of the examination.

E. Certifies that the answers given in the medical history questionnaire are correct and true.

Athlete Signature _____ Date _____