EXAMINEE MEDICAL QUESTIONNAIRE

Every examinee must sign and submit this medical questionnaire

Name:				
Age:		Gender: M ☐ F ☐	Rank:	
Address:				
State:		City:	Zip:	
Club:				
Region:				

Do you have a history of any of the following conditions? Please check all that apply to you.
If you answer Yes to any, please explain:

Condition	Yes w/Explanation	No
Heart Murmur	☐	☐
Hypertension	☐	☐
Recent Infection	☐	☐
Bone fracture in past 6 months	☐	☐
Concussion or severe head injury in past 6 months	☐	☐
Seizures	☐	☐
Eye Injury	☐	☐
Severe bone bruises requiring padding	☐	☐
Kidney injury	☐	☐
Allergy to medication (list all)	☐	☐
Other	☐	☐

Are you currently taking any medications? (list all)

Signature of Examinee :_____ Date: _____