

INTERIM MEDICAL HISTORY

Have you had any serious illness, disease, injury, operation, mental illness, infection, accident, or any other significant medical condition during the past year (12 months)? If yes, please explain: back injury YES NO

Did this medical condition or any other medical condition require surgery? If yes, please explain: YES NO

Have you been hospitalized or examined by a physician other than the team physician for any type of medical condition during the past year (12 months)? If yes, for what reason? Major depressive disorder YES NO

Have you been out of the United States within the last three (3) months? If yes, give an explanation: home YES NO

Have you had a concussion during the past year (12 months) that was not evaluated by our team physician? If yes, give an explanation, including dates and location. YES NO

Have you had any immediate relative die suddenly in the past year (12 months)? If so, what was the cause of death? YES NO

During the past year (12 months) have you had dizziness, fainting, chest pain, racing or skipped heartbeat? If yes, please give a brief explanation. YES NO

Have you had any skin problems in the past year? If yes, please explain and include medications: YES NO

Do you have corrective lenses? If yes, when was your last eye exam? 3 months YES NO

Do you wear any protective devices (special pads, braces, neck rolls, eye guards) during practice/competition? If yes, please explain: YES NO

Have you had significant weight loss or weight gain in the past year (12 months)? If yes, please explain: YES NO

Complete the chart below and give details to the right if you have sustained injuries during the last twelve (12) months

	YES	NO	R	L	
HEAD		<input checked="" type="radio"/>			
NECK		<input checked="" type="radio"/>			
SHOULDER		<input checked="" type="radio"/>			
ARM:		<input checked="" type="radio"/>			
ELBOW		<input checked="" type="radio"/>			
FOREARM		<input checked="" type="radio"/>			
WRIST		<input checked="" type="radio"/>			
HAND		<input checked="" type="radio"/>			
FINGERS		<input checked="" type="radio"/>			
CHEST		<input checked="" type="radio"/>			
SPINE	<input checked="" type="radio"/>	<input type="radio"/>			<u>spondylolithesis, herniated disc, stress reaction</u>
ABDOMEN		<input checked="" type="radio"/>			
PELVIS		<input checked="" type="radio"/>			
HIP		<input checked="" type="radio"/>			
THIGH		<input checked="" type="radio"/>			
KNEE		<input type="radio"/>	<input checked="" type="radio"/>		<u>tendonitis; fine now, just trouble with running</u>
LEG		<input checked="" type="radio"/>			
ANKLE	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>		<u>sprained it; fine now</u>
FOOT		<input checked="" type="radio"/>			
TOES		<input checked="" type="radio"/>			

If you have any additional conditions, problems, or comments that have not been addressed thoroughly in the above questionnaire, please use the space below to inform us so that we may be able to better serve you with our medical care:

asthma

All statements and answers in the above medical history questionnaire are true and complete to the best of my knowledge. I have no abnormality, limitation or restriction not mentioned in this record. I understand that this information is to help determine my fitness to participate in athletics, and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur.

DATE 08/19/10 PRINTED NAME OF ATHLETE Sasha Menu Carey
 SIGNATURE OF ATHLETE [Signature]