NEW ENGLAND FOOTBALL LEAGUE
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# SELF ADMINISTERED HEALTH HISTORY

TEAM NAME:_____ PLAYER NUMBER:_____

PLAYER NAME:_____ DATE OF BIRTH:_____

EMERGENCY CONTACT PERSON:_____ PHONE #:_____

The purpose of this questionnaire is to assist us in providing quality care by obtaining your health history. This questionnaire is part of your confidential medical record.

MEDICAL INFORMATION *(Please list any current or past medical injuries)*

_____
_____
_____
_____

ALLERGIES

Do you have any allergies or sensitivities to medication, food, shellfish, bee stings, etc?
_____YES _____NO If yes, please list:_____
_____

CURRENT MEDICATIONS

Please list all medications you are now taking and the doctor's name prescribing the medication.

| | | | |
|---|---|---|---|
| _____ | | _____ | |
| Medication | Doctor | Medication | Doctor |
| _____ | | _____ | |
| Medication | Doctor | Medication | Doctor |

HOSPITALIZATION/PAST SURGERY

Have you been hospitalized in the past 5 years? _____YES _____NO If yes, why?
_____

Please list any past surgeries (include all procedures involving metal implants):_____
_____

CARDIAC CONDITIONS

Have you ever been treated for a heart condition? If yes, explain condition:_____
_____

Are you currently being treated by a physician for your heart condition? _____YES _____NO
Physician:_____

| | YES | NO |
|---|---|---|
| Asthma or Respiratory Disorders | ____ | ____ |
| Bleeding Disorders (i.e Cerebral Hemorrhage or History of blood clots) | ____ | ____ |
| Diabetes | ____ | ____ |
| Fainting/Dizzy Spells | ____ | ____ |
| Hearing problems or use of hearing aid | ____ | ____ |
| Heart Disease | ____ | ____ |
| Pacemaker | ____ | ____ |
| Hepatitis | ____ | ____ |
| Hypertension or Hypotension | ____ | ____ |
| Seizures or Fainting Disorder | ____ | ____ |
| Tuberculosis | ____ | ____ |
| Vision problems | ____ | ____ |
| Skin sensitivities or open wounds | ____ | ____ |
| Bowel or bladder incontinence | ____ | ____ |

_____ _____
Player Signature Date