CALIFORNIA BASKETBALL ASSOCIATION

medical history form

To be completed by Athlete.

Athlete's Name: _____ Date _____

1. Have you had an injury before? ☐ **Yes** ☐ **No** If yes, please list your injuries and specify date(s)

_____

2. Check which apply to your current condition

☐ Athletic injury ☐ Work related injury ☐ Injury related to lifting ☐ Cause unknown

☐ Motor Vehicle accident ☐ Injury related to falling ☐ Other _____

3. Have you had a surgery related to any of your injuries? ☐ **Yes** ☐ **No** If yes, please specify the date(s)

_____

4. Do you have, or have you had, any of the following: *(Check each question, YES or NO)*

	Yes	No		Yes	No		Yes	No
Diabetes	☐	☐	Hypoglycemia	☐	☐	Stroke	☐	☐
Chest Pain/Angina	☐	☐	Osteoarthritis	☐	☐	Hernia	☐	☐
High Blood Pressure	☐	☐	Osteoporosis	☐	☐	Metal Implants	☐	☐
Heart Disease	☐	☐	Heart Attack	☐	☐	Seizures	☐	☐
Heart Palpitations	☐	☐	Pacemaker	☐	☐	Dizziness/Fainting	☐	☐
Headaches	☐	☐	Fractures	☐	☐	Urine Leakage	☐	☐
Kidney Problems	☐	☐	Surgeries	☐	☐	Rheumatoid Arthritis	☐	☐
Ringing in Your Ears	☐	☐	Cancer	☐	☐	Bowel/Bladder	☐	☐
Dysfunction	☐	☐	Skin Abnormalities	☐	☐	Smoking	☐	☐
Liver/Gallbladder Prob.	☐	☐	Asthma/Breathing Prob.	☐	☐	Nausea/Vomiting	☐	☐

If you answered **Yes** to any of the items above, please briefly explain and give the date, include any pertinent information regarding your past medical history _____

_____

5. Do you have any allergies (including medicines or supplements)? ☐ **Yes** ☐ **No** If yes, please explain

_____

6. Are you presently taking any medications? ☐ **Yes** ☐ **No** If yes, please list the medication and what condition it is for _____

_____

emergency contact information

Name _____ Relation_____

Home Phone _____ Cell Phone_____

medical insurance information

Insurance Name _____ Policy # _____

Address _____

City _____ State _____ Zip_____ Country_____

Phone _____ Fax_____

(Country Code, Area Code, Phone Number) *(Country Code, Area Code, Phone Number)*

Each Athlete is required to take a physical examination before beginning any training or game competition administered by or for the CBA or coach.

The CBA is a California Not for Profit Corporation

All games held at **USESS CENTER** • 950 South Central Ave., Compton, CA 90220

CALIFORNIA BASKETBALL ASSOCIATION

physical examination form

To be completed by Doctor.

Preparticipation Physical Examination

Athlete's First Name _____ Last Name _____

Gender: ____ Male ____ Female Date of Birth _____/_____/_____ Age _____
(month/day/year)

Height _____ Weight_____ % Body fat (optional) Pulse _____ BP _____

Vision R 20/____L20/___ Corrected: Y N Pupils: Equal _____ Unequal _____

Follow-Up questions on more sensitive issues	**Yes**	**No**
1. Do you feel stressed out or under a lot of pressure?	☐	☐
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	☐	☐
3. Do you feel safe?	☐	☐
4. Have you ever tried cigarette smoking, even 1 or 2 puffs?	☐	☐
5. Do you currently smoke cigarettes?	☐	☐
6. During the past 30 days, did you use chewing tobacco, snuff or dip?	☐	☐
7. During the past 30 days, have you had at least 1 drink of alcohol?	☐	☐
8. Have you ever taken steroid pills or shots without a doctor's prescription?	☐	☐
9. Have you ever taken any supplements to help you gain or lose weight or improve your performance?	☐	☐
10. Questions from the Youth Risk Behavior Survey (http://www.cdc.gov/HealthyYouth/yrbs/index.htm) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc.	☐	☐

Notes: _____

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary *(males only)**			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

**Multiple-examiner set up only. Having a third party present is recommended for the genitourinary examination.*

Notes: _____

Name of Physician (print) _____Date_____ Phone_____

Physician's Signature _____

Street Address _____

City _____ State _____ Zip_____ Country_____

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CALIFORNIA BASKETBALL ASSOCIATION

physical examination form History

Preparticipation Physical Examination Pg. A

Date of Exam _____/_____/_____

To be completed by Athlete.

(Please print clear and legibly)

Athlete's First Name _____ Last Name _____

Gender: ____ Male ____ Female Date of Birth _____/_____/_____ Age _____
(month/day/year)

Address _____

City _____ State _____ Zip_____ Country_____

Home Phone _____ Cell Phone_____
(Country Code, Area Code, Phone Number) *(Country Code, Area Code, Phone Number)*

Personal Physician _____ Phone_____

In case of emergency, contact Name_____

Relationship_____ Phone (H)_____ (W)_____

Choose **Yes** or **No** for each question. If you don't know the answer to a question, circle the number. Explain **Yes** answers at the end of the list.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or nonprescription *(over-the-counter)* medications or pills?	☐	☐
4. Do you have any allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have *(check all that apply)*: ☐ High blood pressure ☐ High cholesterol ☐ A heart murmur ☐ A heart infection		
10. Has a doctor ever ordered a test for your heart? *(for ex., ECG, Echocardiogram)*	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below. Head Neck Shoulder Upper Arm Elbow Forearm Hand/Fingers Chest Upper Back Lower Back Hip Thigh Knee Calf/Shin Ankle Foot/Toes	☐	☐
18. Have you ever had any broken or fractured bones or dislocated joints? If yes, circle below. Head Neck Shoulder Upper Arm Elbow Forearm Hand/Fingers Chest Upper Back Lower Back Hip Thigh Knee Calf/Shin Ankle Foot/Toes	☐	☐

continued

CALIFORNIA BASKETBALL ASSOCIATION

physical examination form History

Preparticipation Physical Examination Pg. B

19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below. ☐ ☐

    Head Neck Shoulder Upper Arm Elbow Forearm Hand/Fingers Chest
    Upper Back Lower Back Hip Thigh Knee Calf/Shin Ankle Foot/Toes

20. Have you ever had a stress fracture? ☐ ☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial *(neck)* instability? ☐ ☐
22. Do you regularly use a brace or assistive device? ☐ ☐
23. Has a doctor ever told you that you had asthma or allergies? ☐ ☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise? ☐ ☐
25. Is there anyone in your family who as asthma? ☐ ☐
26. Have you ever used an inhaler or taken asthma medicine? ☐ ☐
27. Were you born without or are you missing a kidney, an eye, testicle, or any other organ? ☐ ☐
28. Haver you had infectious mononucleosis *(mono)* within the last month? ☐ ☐
29. Do you have any rashes, pressure sores, or other skin problems? ☐ ☐
30. Have you had a herpes skin infection? ☐ ☐
31. Have you ever had a head injury or concussion? ☐ ☐
32. Have you been hit in the head and been confused or lost your memory? ☐ ☐
33. Have you ever had a seizure? ☐ ☐
34. Do you have headaches when you exercise? ☐ ☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? ☐ ☐
36. Have you ever been unable to move your arms or legs after being hit or falling? ☐ ☐
37. When exercising in the heat, do you have severe muscle cramps or become ill? ☐ ☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? ☐ ☐
39. Have you had any problems with your eyes or vision? ☐ ☐
40. Do you wear glasses or contact lenses? ☐ ☐
41. Do you wear protective eye wear, such as goggles or a face shield? ☐ ☐
42. Are you happy with your weight? ☐ ☐
43. Are you trying to gain or lose weight? ☐ ☐
44. Has anyone recommended you change your weight or eating habits? ☐ ☐
45. Do you limit or carefully control what you eat? ☐ ☐
46. Do you have any concerns that you would like to discuss with a doctor? ☐ ☐

FEMALES ONLY

47. Have you ever had a menstrual period? ☐ ☐
48. How old were you when you had your first menstruel period? _____
49. How many periods have you had in the last 12 months? _____

Explain YES answers here _____

_____

_____

I hereby state, that to the best of my knowledge, my answers to the above questions are complete and correct.

Athlete's Signature_____ Date_____