



Athlete Medical History Questionnaire

Name: _____ Sport(s): _____
 First Middle Last

DOB: _____ Banner ID: _____ SSN: _____ Fr So Jr Sr _____

Home Address: _____

School Address: _____

Home Phone: _____ School Phone: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Please circle "Yes" or "No" and provide additional details where requested on this form. All information is confidential.

Section A: General Medical

- | | | | |
|----|--|-----|----|
| 1 | Have you had a medical illness or injury that caused you to miss 1 week or more of sports/physical activity this past year?
List: _____ | Yes | No |
| 2 | Do you have an ongoing or chronic illness? _____ | Yes | No |
| 3 | Are you allergic to any medication (Ex. aspirin, penicillin, sulfa, etc.)?
List: _____ | Yes | No |
| 4 | Do you have any food allergies?
List: _____ | Yes | No |
| 5 | Do you ever have itchy eyes? | Yes | No |
| 6 | Do you ever have itching of the nose or sneezing spells? | Yes | No |
| 7 | Do you have any seasonal allergies that require medical treatment?
List: _____ | Yes | No |
| 8 | Do you take any over the counter medication(s)?
List: _____ | Yes | No |
| 9 | Do you take any prescribed medication on a permanent or semi-permanent basis (Ex. steroids, birth control pills, anti-inflammatories, antibiotics, etc.)?
List: _____ | Yes | No |
| 10 | Have you ever had a rash or hives develop during or after exercise? | Yes | No |
| 11 | Have you ever had a seizure? | Yes | No |
| 12 | Have you ever been told that you have epilepsy?
List medications: _____ | Yes | No |

- | | | | |
|----|---|------------|----------|
| 13 | Do you have or have you ever been treated for diabetes?
List medications: _____ | Yes | No |
| 14 | Have you ever been told that you were anemic?
When: _____ | Yes | No |
| 15 | Have you ever been told that you have sickle cell anemia? | Yes | No |
| 16 | Have you had a severe viral infection (Ex. myocarditis, mononucleosis, etc.)
within the last 6 months? | Yes | No |
| 17 | Do you have or have you ever had rheumatic fever?
Give dates(s) _____ | Yes | No |
| 18 | Do you have or have you ever had lung disease (Ex. pneumonia, etc.)?
Give dates(s) _____ | Yes | No |
| 19 | Do you have or have you ever had kidney disease and/or infections?
Give dates(s) _____ | Yes | No |
| 20 | Do you have or have you ever had liver disease (Ex. mononucleosis, hepatitis)? | Yes | No |
| 21 | Do you or have you ever had a hernia or "rupture"?
Has it been repaired? | Yes
Yes | No
No |
| 22 | Do you have any current skin problems (Ex. itching, rashes, acne, warts,
fungus, or blisters)? | Yes | No |
| 23 | Are you missing one of a set of paired organs (Ex. kidneys, eye, etc.)?
List: _____ | Yes | No |
| 24 | Do you now or have you ever had herpes? | Yes | No |
| 25 | Do you have any other conditions of which we should be aware (ulcers,
tendinitis, etc.)? Specify and give details: _____ | Yes | No |
| 26 | Have you had any problems with your eyes or vision? | Yes | No |
| 27 | Do you wear glasses, contacts, or protective eyewear during competition? | Yes | No |
| 28 | Do you wear any of the following dental appliances?
Circle those which apply: permanent bridge / removable retainer
removable partial plate / permanent crown or jacket / braces /
permanent retainer / full plate | Yes | No |
| 29 | Do you feel stressed out? | Yes | No |
| 30 | Have you ever become ill from exercising in the heat? | Yes | No |
| 31 | Have you ever passed out in the heat? | Yes | No |
| 32 | Have you ever had heat or muscle cramps? | Yes | No |

Section B: Cardiovascular / Respiratory

- | | | | |
|----|--|-----|----|
| 33 | Do you ever have wheezing? | Yes | No |
| 34 | Does running ever cause chest tightness, cough, wheezing, or prolonged
shortness of breath? | Yes | No |

- | | | | |
|----|---|-----|----|
| 35 | Have you ever had chest tightness, cough, wheezing, asthma, or other chest (lung) problems which have made it difficult for you to perform in sports? | Yes | No |
| 36 | Have you ever missed school, work, or practice because of chest tightness, cough, wheezing, or prolonged shortness of breath? | Yes | No |
| 37 | If you have been told you have asthma, what medications(s) have you taken to treat it?
List: _____ | Yes | No |
| 38 | Do you ever have chest tightness? | Yes | No |
| 39 | Do you have chest tightness/pain at night? | Yes | No |
| 40 | Do you have shortness of breath at night? | Yes | No |
| 41 | Have you ever been told to give up sports because of health problems? | Yes | No |
| 42 | Has anyone in your family under age 50 died suddenly? | Yes | No |
| 43 | Do you have or have you ever had high blood pressure?
List medications: _____ | Yes | No |
| 44 | Do you have or have you ever had high cholesterol? | Yes | No |
| 45 | Do you have trouble breathing or do you cough during or after activity? | Yes | No |
| 46 | Have you ever been dizzy during or after exercise? | Yes | No |
| 47 | Have you ever fainted or passed out when exercising? | Yes | No |
| 48 | Have you ever had chest pain during or after exercise? | Yes | No |
| 49 | Do you have or have you ever had racing of your heart or skipped heartbeats? | Yes | No |
| 50 | Do you get tired more quickly than your friends do during exercise? | Yes | No |
| 51 | Do you have or have you ever been told you have a heart murmur?
Give dates(s) _____ | Yes | No |

Section C: Orthopedic

- | | | | |
|----|--|-----|----|
| 52 | Have you been "knocked out," become unconscious, or lost your memory?
Give dates(s) _____ | Yes | No |
| 53 | Have you ever had a concussion or other head injury?
Give dates(s) _____ | Yes | No |
| 54 | Have you ever had your head or neck x-rayed? | Yes | No |
| 55 | Have you stayed overnight in a hospital due to head injury?
Give dates(s) _____ | Yes | No |
| 56 | Do you have frequent or severe headaches? | Yes | No |
| 57 | Have you ever had a neck injury involving bones, nerves or discs that disabled you for a week or longer?
Type of injury: _____ Dates: _____ | Yes | No |
| 58 | Have you ever had numbness or tingling in your arms, hands, legs, or feet? | Yes | No |

- 59 Have you ever had a stinger, burner, or pinched nerve? Yes No
- 60 Have you ever injured your back? Yes No
 Type of injury: _____ Dates: _____
- 61 Do you have back pain? Yes No
 Circle those that apply: seldom / occasionally / frequently /
 with heavy lifting / with vigorous exercise
- 62 Have you had any other problems with pain or swelling in muscles, tendons
 bones, or joints? If yes, circle those that apply and explain. Yes No
 head / neck / back / chest / shoulder / upper arm / elbow /
 forearm / wrist / hand / finger(s) / hip / thigh / knee / shin /
 calf / ankle / foot / toe(s)

- 63 Have you had a broken bone or fracture? R or L Yes No
 What bone(s) _____ Dates: _____
- 64 Have you had a shoulder injury that disabled you for a week or longer? Yes No
 Type of injury: _____ Dates: _____
- 65 Have you ever had shoulder surgery? R or L Yes No
 What was done & why _____
 Dates: _____
- 66 Have you injured your knee? R or L Yes No
 When: _____ What was done? _____ Time Missed: _____
- 67 Have you been told by a doctor or athletic trainer that you injured the
 cartilage in your knee? R or L Yes No
 Dates: _____
- 68 Have you been told by a doctor or athletic trainer that you injured the
 ligaments in your knee? R or L Yes No
 Dates: _____
- 69 Have you ever had knee surgery? R or L Yes No
 What was done? _____ Dates: _____
- 70 Have you had a severe ankle sprain? R or L Yes No
 When: _____ What was done? _____ Time Missed: _____
- 71 Do you have a pin, plate, or screw in your body? Yes No
 Where? _____ Dates: _____
- 72 Have you had any surgery? Yes No
 Specify and give details: _____

- 73 Do you use any special protective or corrective equipment or device that is
 not usually used for your sport(s) (ex. Knee brace, special neck roll, foot
 orthotics, hearing aid, etc.) _____ Yes No

Section D: Nutrition/Diet/Supplements

- 74 Do you want to weigh more or less than you do now? Yes No
- 75 Do you lose weight regularly to meet weight requirement for your sport? Yes No
- 76 Do you take any over the counter dietary supplements (herbs, vitamins, minerals, protein, etc.)? Yes No
 List: _____
- 77 Have you ever taken any dietary supplements or vitamins to help you gain or lose weight or improve your performance? Yes No
 List: _____
- 78 Which of the following dietary supplement have you taken during the past years?
- | | |
|--|------------------------------|
| _____ Multi-vitamins/mineral | _____ Protein drinks or bars |
| _____ Individual vitamin (ex. Vitamin C, etc.) | _____ Energy drinks or bars |
| _____ Individual Mineral (ex. Iron, calcium, etc.) | _____ Creatine |
| _____ Protein powders or pills | _____ Amino acid pills |
| _____ Herbals (ex. Ginseng, Echinacea, etc.) | _____ Other - please list |
- 79 If you took any dietary supplements during the past year, how frequently did you take them?
- | | | | |
|----------------------------|---|-------------------|--|
| _____ Daily | _____ Occasionally | _____ Once a week | |
| _____ Several times a week | _____ Specific times (travel, training) | | |
- 80 Check the reasons for using dietary supplements during the past year?
- | | |
|--|---------------------------------|
| _____ To make up for an inadequate diet | _____ To lose weight |
| _____ To treat a medical condition or injury | _____ To have more energy |
| _____ To increase muscle mass/gain weight | _____ To enhance my performance |
| _____ To prevent illness and disease | _____ No specific reason |

FEMALES ONLY

- 81 When was your first menstrual period? _____
- 82 When was your most recent menstrual period? _____
- 83 How much time do you usually have from the start of one period to the start of another? _____
- 84 How many periods have you had in the last year? _____
- 85 What was the longest time between periods in the last year? _____
- 86 Are you pregnant, or you suspect that you may be pregnant? Yes No
(If the answer is "Yes," this does not necessarily preclude your participation from your sport. However, you must present a clearance from your physician stating that your sport participation will not be detrimental to the pregnancy.)

****Optional****

Section E: Immunizations

- 87 Please give dates of your last immunizations:
- | | | | |
|---------------|-------------|-------------------|--|
| Tetanus _____ | Polio _____ | Hepatitis B _____ | |
| | MMR _____ | Chicken Pox _____ | |

Please complete last page.

I hereby state that the questions on this form have been answered completely and truthfully to the best of my knowledge.

Student-Athlete Signature

Date

Student-Athlete Name - Please Print

Legal Guardian Signature

Date

Legal Guardian Name - Please Print

Relationship to athlete

**** Office Only ****

Noteworthy medical conditions/issues as per Medical Staff review:

Medical Staff Signature

Date

Name - Please print

Phone

Cardiovascular Screening

This section may be completed upon arrival at IUP as part of a yearly screening, unless athlete is obtaining a physical by a licensed physician prior to arrival.

Date: _____

Ht.: _____

Practioner: _____

Wt.: _____

Practioner: _____

BP: _____

Practioner: _____

Pulse: _____

Practioner: _____

Optional:

Lungs: _____

Practioner: _____

Heart: _____

Practioner: _____