

STATE UNIVERSITY OF NEW YORK- POTSDAM
Student-Athlete Health History Questionnaire Form

The information contained in this medical history form will only be used by the Sports Medicine Department and Student Health Services of SUNY Potsdam for purposes of determining if there is any pretense of a health threat/ risk to you on the athletic field. This information will remain **CONFIDENTIAL** at all times.

(Please print clearly in **BLUE** or **BLACK INK ONLY!**)

Name _____ Grad Yr _____ Date _____
Social Security # _____ - _____ - _____ Date of Birth (mm/dd/yyyy) ____/____/____
Sport(s) _____ Email address/AIM screen name _____
Height _____ Weight _____ Right Handed Left Handed
Campus Phone # _____ Residence Hall _____ Rm# _____ Cell# (____) _____
Home Address: _____ Off Campus Add: _____

(City) (ST/Prov) (Zip code) (City)
Home Phone # (____) _____ Off Campus Phone# (____) _____

Emergency Contact -Parent/Guardian:

Name: _____ Relationship: _____
Home Phone# (____) _____ Work Ph#(____) _____ Cell Ph#(____) _____

Primary Insurance: (if you have a secondary policy please attach information) Subscriber DOB: _____
SS#: _____

Name on Insurance: _____ Name of Insurance: _____
Identification #/Policy #: _____ Group # _____ Ins. PH#: _____
Insurance Address: _____

ARE YOU COVERED UNDER THE ABOVE POLICY FOR ATHLETICS (in the U.S.)? YES NO
Does your insurance require Pre-Authorization for Services? YES NO

Primary Care Physician: _____ Phone # (____) _____
Orthopedic Physician: _____ Phone # (____) _____

I. Cardiovascular Risk Factors:

Have you ever had chest pain and/or shortness of breath during or after exercise/practice? YES NO

▪ Please describe _____

Have you ever felt dizzy, lightheaded, and/or passed out during or after exercise/ practice? YES NO

▪ Please describe _____

Have you ever been told that you have a heart murmur? YES NO

▪ Please describe _____

Has any family member or relative died of heart problems and/or of sudden death before age 50? YES NO

▪ Please describe _____

Have you or anyone in you family been told you/ they have High Blood Pressure? YES NO

▪ Please describe _____

II. Allergies:

Have you ever been diagnosed with Season Allergies? What meds do you take? YES NO

▪ Please describe _____

Are you allergic to and/or ever had an unfavorable/ allergic reaction to any medications/ food? YES NO

▪ Please describe _____

Are you allergic to and/or ever had an unfavorable/ allergic reaction to bee stings, insect bites, etc? YES NO

▪ Please describe _____

III. Asthma:

Have you ever been diagnosed with Asthma and/ or Exercised Induced Asthma? YES NO

▪ Date(s)? _____ Please describe _____

Are you presently taking/ have you previously taken *any* Asthma Medications/Use an Inhaler? YES NO

▪ Please describe _____

How often do you use your rescue inhaler/ per week? _____

How many *acute asthma attacks* have you had in the past 12 months? _____

Have you ever been hospitalized as a result of an attack? YES NO

▪ Date(s)? _____ Please describe _____

IV. Head Injuries/Concussion:

Have you *ever* suffered a Head Injury/ Concussion (*no matter how minor*)? YES NO

▪ List Date(s)/ Time (e.g. practices or games) Missed _____

▪ Please describe _____

Have you ever been evaluated by a Doctor for a Head Injury/ Concussion? YES NO

- Please describe _____

Were any Diagnostic Tests Performed? YES NO (check all that apply)

- X-Ray MRI CT-Scan Neuropsychological Testing Other _____

Have you ever been Hospitalized, Knocked Out, Become Unconscious, and/ or Lost Your Memory Due to a Head Injury/ Concussion? YES NO

- Please describe _____

Have you ever been advised *not to participate in athletic activities* due to a Head injury/ Concussion? YES NO

- Please describe _____

Do you suffer from *headaches*? YES NO

- When? Everyday 1-2 Times/ Week 1-2 Times/Month
- Where are your Headaches Located? Left Side of Head Right Side of Head
 Front of Head Back of Head All Over Your Head

Do you have a history of Migraine Headaches? YES NO

- How often _____ Please describe _____
- Medications Taken for Migraines? _____

Have you had headaches for More Than Three (3) Months? YES NO

- If yes, please explain _____

V. Eye/ Ear/ Nose/ Throat/ Dental:

When was your Last Eye Exam? _____ Findings? _____

Do you routinely wear Glasses, Contact Lenses, or Special Devices/ Equipment? YES NO

- Type and how often _____

Have you ever suffered an Injury to your Eye(s) and/or been advised that you have an Eye Disorder? YES NO

- Please Describe _____

Have you ever suffered an Injury to your Ear(s), Nose and/or Throat? YES NO

- Please Describe _____

Have you ever suffered an Injury to your Mouth, Jaw, and/or Teeth? YES NO

- Please Describe _____

VI. Cervical Spine/ Neck:

Have you ever suffered an injury to your Cervical Spine and/or Neck? YES NO

- List Date(s)/ Time (e.g. practices or games) Missed _____
- Please describe _____

Were any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have you ever experienced Numbness and/or Tingling in Your Arms/Fingers? YES NO

- Date(s)? _____ Please describe _____

VII. Shoulder/Upper Arm:

Have you ever suffered an Injury/Surgery to your Shoulder/Upper Arm? YES NO

- List Date(s)/ Time (e.g. practices or games) Missed _____
- Please Describe _____

Were any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Elbow/ Forearm:

Have you ever suffered an Injury/Surgery to your Elbow/Forearm? YES NO

- List Date(s)/ Time (e.g. practices or games) Missed _____
- Please Describe _____

Were any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Wrist, Hand, & Fingers:

Have you ever suffered an Injury/Surgery to your Wrist(s), Hand(s), and/or Finger(s)? YES NO

- List Date(s)/ Time (e.g. practices or games) Missed _____
- Please Describe _____

Were any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Spine/ Low Back/ Sacroiliac Joint:

Have you ever suffered an Injury/Surgery to your Spine/ Low Back/ Sacroiliac Joint? YES NO

- List Date(s)/ Time (e.g. practices or games) Missed _____
- Please Describe _____

Were any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have you ever had Numbness/ Tingling Down One (1) or Both Legs? YES NO

- Date(s)/ Time (e.g. practices or games) Missed _____
- Please Describe _____

Hip/ Groin:

Have you ever had an Injury/Surgery to your Hip/ Groin (*including hernias and/or sports hernias*)? YES NO

- List Date(s)/ Time (e.g. practices or games) Missed _____
- Please Describe _____

Were any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Thigh/ Hamstring/ Quadriceps:

Have you ever suffered an Injury/Surgery to your Thigh/ Hamstring/ and/or Quadriceps? YES NO

- List Date(s)/ Time (e.g. practices or games) Missed _____
- Please Describe _____

Were any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Knee/ Patella:

Have you ever suffered an Injury/Surgery to your Knee and/or Patella (kneecap)? YES NO

- List Date(s)/ Time (e.g. practices or games) Missed _____
- Please Describe _____

Were any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Ankle/ Lower Leg:

Have you ever suffered an Injury/Surgery to your Ankle/ Lower Leg? YES NO

- List Date(s)/ Time (e.g. practices or games) Missed _____
- Please Describe _____

Were any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Do you presently Tape Your Ankle(s) Use Ankle Brace(s)

- Please Describe _____

Foot/ Toes:

Have you ever suffered an Injury/Surgery to your Foot/ Toe(s)? YES NO

- List Date(s)/ Time (e.g. practices or games) Missed _____
- Please Describe _____

Were any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Ribs/ Thorax/ Chest:

Have you ever suffered an Injury/Surgery to your Ribs/ Thorax/ and/or Chest? YES NO

- List Date(s)/ Time (e.g. practices or games) Missed _____
- Please Describe _____

Were any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

VIII. Abdomen:

Have you ever suffered an Injury/Surgery to your Stomach, Abdomen, Intestines, or Rectum? YES NO

- List Date(s)/ Time (e.g. practices or games) Missed _____
- Please Describe _____

Were any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Do you routinely suffer from severe or recurrent abdominal pain? YES NO

- Please Describe _____

Do you only have One of Two Paired, Functioning Organs (e.g. kidney, testicle, ovary, etc.)? YES NO

- Please Describe _____

IX. Medical Testing:

Have you ever been diagnosed with a Communicable Disease (STD, HIV, Hepatitis A,B, or C, Herpes Simplex, Syphilis, Tuberculosis)? If yes, please explain _____

X. Prescription Medications:

Please List **ALL** Prescription & Over-the-Counter Medications that you are **CURRENTLY** Taking or **HAVE TAKEN** in the PAST Two (2) Years, & For What Purpose:

<u>MEDICATION</u>	<u>PURPOSE</u>	<u>DOSAGE</u>	<u>DATE(S)</u>

XI. Supplements/ Ergogenic Aids:

Please List **ALL** Supplements/ Ergogenic Aids that you are **CURRENTLY** Taking or **HAVE TAKEN** in the PAST Two (2) Years, & For What Purpose:

<u>SUPPLEMENT</u>	<u>PURPOSE</u>	<u>DOSAGE</u>	<u>DATE(S)</u>

XII. Heat Related Problems:

Have you ever suffered from a heat related Injury/ Illness? YES NO (check all that apply)

- Heat Cramps- Date(s)? _____
- Heat Syncope (Fainting)- Date(s)? _____
- Heat Exhaustion- Date(s)? _____
- Heat Stroke- Date(s)? _____
- Please Describe any of the above _____

XIII. Diabetic History:

Have you ever been diagnosed with Diabetes? YES NO

- Date _____

Are you presently taking or have you Taken Any Diabetic Medications? YES NO

<u>MEDICATION</u>	<u>FORM</u>	<u>DOSAGE</u>	<u>FREQUENCY</u>

XIV. For Females Only:

- YES NO Have you had menstrual periods within the past 12 months?
- If yes, how many? _____ When was your most recent menstrual period? _____
 - How much time do you usually have from the start of one period to the start of another?

 - What was the longest time between menstrual periods within the past year? _____
- YES NO Do you have painful or heavy menstrual periods?
- YES NO Do you take any medications during your menstrual periods? If yes, what? _____
- YES NO Do you take birth control pills? If yes, what brand? _____

XV. Please Answer: (All questions are strictly **CONFIDENTIAL** & will not be shared with parents or coaches!)

- YES NO Have you ever had any injury or illness other than those already noted?
- YES NO Do you have any ongoing or chronic illness?
- YES NO Have you ever been hospitalized overnight?
- YES NO Are you currently under a physician's care for any medical condition?
- YES NO Have you ever been told by a physician to restrict your activity or not to participate in a sport?
- YES NO Have you ever been under the care of a psychiatrist and/or psychologist?
- YES NO Have you consulted and/or been under the care of a chiropractor, hypnotist, acupuncturist, massage therapist, spiritual healer, and/or other such practitioner in the past five (5) years?
- YES NO Have you ever had a rash or hives develop during and/or after exercise?
- YES NO Do you cough, wheeze or have trouble breathing during or after exercise/ practice?
- YES NO Have you ever been told that you have a kidney disease?
- YES NO Have you ever had rubella ("German Measles") and/or Rubeola ("red measles")?
- YES NO Have you ever had a stomach and/or duodenal ulcer?
- YES NO Have you had a viral infection (i.e. mononucleosis, myocarditis, etc.) within the past six months?
- YES NO Have you ever had seizures, convulsions, and/or epilepsy?
- YES NO Have you ever had gall bladder disease and/or a urinary problem?
- YES NO Do you have ringing in your ears or trouble hearing?
- YES NO Have you ever had an abnormal chest x-ray and/or pneumonia?
- YES NO Do you require any special equipment (braces, neck rolls, dental, orthotics, hearing aids, etc.)?
- YES NO Have you ever had the chickenpox? If yes, when? _____
- YES NO Are you aware of any reason why you should not participate in intercollegiate athletics at SUNY Potsdam at this time?
- YES NO Have you had a tetanus booster within the past five (5) years? If yes, when? _____
- YES NO Have you received the Hepatitis B (HBV) Vaccination series (all 3 shots)? If yes, when? _____
- YES NO Do you smoke cigarettes, use smokeless tobacco, or use tobacco in any form?
- YES NO Do you use alcohol? If yes, how often? _____
- YES NO Have you ever used/ tried marijuana, cocaine, or any other illicit "street" drugs?
- YES NO Do you have any questions regarding drugs, tobacco, or alcohol?
- YES NO Do you feel stressed out? If yes, do you feel as though you get the necessary support to deal with your stress?
- YES NO Have you had a weight change (loss or gain) of greater than 10 pounds in the last year?
- YES NO Are you a vegetarian? If yes, what type? _____
- YES NO Do you regularly lose weight to participate in your sport?

- YES NO Do you want to weigh more or less than you presently do?
 YES NO Have you ever felt forced to limit you food intake due to concerns about your weight and/or body size?
 YES NO Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorders?
 YES NO Would you like to meet with a health educator to discuss your nutritional needs or eating habits?

If you answered **YES** to any of the above, please explain: _____

Please describe below any further information, which is knowledgeable to you and not required on this form.

I, the undersigned, hereby acknowledge, affirm, and represent that all statements on pages one (1) through eight(8) are true and accurate to the best of my knowledge; and the no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that my health and physical welfare my be jeopardized as a result and that I may suffer physical harm.

 Student-Athlete Signature

 Date

 Student-Athlete Print Name

 Parent/Guardian Signature (*if under 18 years of age*)

 Date

 Parent/ Guardian Print Name

 Witness

 Date

Reviewed By:

 Reviewer's Signature

 Date

 Reviewer Print Name