The information contained in this medical history form will only be used by the Athletic Training Department of the State University of New York at Potsdam for purposes of determining if you pose a health threat/risk to yourself on the athletic field. This information will remain **CONFIDENTIAL** at all times.

**ORTHOPEDIC HISTORY:**

### I. Head Injuries / Concussion:

History of Head Injury / Concussion Injury? Yes / No

- List Dates/Time Missed ______________________________________________________
- Describe ___________________________________________________________________

Were Any Diagnostic Tests Performed? Yes / No

- _MRI_  __ CT Scan  __ Neuropsychological Testing  __ Other ________________

Have You Ever Been Hospitalized, Lost Consciousness, and/or Lost Your Memory Due to a Head Injury/Concussion? Yes / No

- Describe ___________________________________________________________________

Do You Suffer From Headaches? Yes / No

- When?  __ Every Day  __ 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 ______________________  Describe ___________________________________
- Medications for Migraines? __________________________________________________

Have You Had Headaches for More Than Three (3) Months? Yes / No

- If yes, explain _____________________________________________________________
II. Cervical Spine / Neck:

History of Cervical Spine / Neck Injury? Yes / No

- List Dates/Time Missed ________________________________
- Describe __________________________________________

Were Any Diagnostic Tests Performed?  __ X-Rays  __ Bone Scan
    __ MRI  __ CT-Scan  __ Other ________________________________

Have You Ever Been Hospitalized for a Cervical Spine / Neck Injury? Yes / No

- When? __________________ Where? __________________________
- Describe ____________________________________________

Have You Ever Had “Burners”, “Stingers”, or Any Brachial Plexus Injury? Yes / No

- How Many? ___________ Date(s)/Time Missed? __________________

Have You Every Had Surgery of Any Kind on Your Cervical Spine / Neck? Yes / No

- When? __________________ Surgeon? _________________________
- Describe ____________________________________________

Do You Presently Wear a Neck Roll or Neck Collar? Yes / No

Do You Presently Wear a “Cowboy Collar” or Helmet Restrictor Plate? Yes / No

Have You Ever Worn or Been Advised to Wear a Neck Roll, Neck Collar, “Cowboy Collar”, and/or Helmet Restrictor Plate? Yes / No

If yes, please explain _______________________________________

III. Shoulder / Upper Arm:

History of Shoulder / Upper arm Injury? Yes / No

- List Dates/Time Missed ________________________________
- Describe __________________________________________

Were Any Diagnostic Tests Performed?  __ X-Rays  __ Bone Scan
    __ MRI  __ CT-Scan  __ Other ________________________________

Have You Ever Been Hospitalized for a Shoulder / Upper Arm Injury? Yes / No

- When? __________________ Where? __________________________
- Describe ____________________________________________

Have You Ever Had Surgery of Any Kind on Your Shoulder / Upper Arm? Yes / No
• When? ______________________ Surgeon? ________________________________
• Describe ____________________________________________________________

Have You Experienced Numbness and/or Tingling in Your Arms/Fingers? Yes / No
• Date(s) ________________________________
• Describe ____________________________________________________________

IV. Elbow / Forearm:

History of Elbow / Forearm Injury? Yes / No
• List Dates/Time Missed ________________________________________________
• Describe ____________________________________________________________

Were Any Diagnostic Tests Performed? (Check all that apply)
__ X-Rays  __ Bone Scan
__ MRI  __ CT-Scan  __ Other _____________________________________________

Have You Ever Been Hospitalized for an Elbow/Forearm Injury? Yes / No
• When? _____________________ Where? ________________________________
• Describe ____________________________________________________________

Have You Ever Had Surgery of Any Kind on Your Elbow/Forearm? Yes / No
• When? _____________________ Surgeon? ________________________________
• Describe ____________________________________________________________

V. Wrist, Hand, & Fingers:

History of Wrist, Hand, and/or Finger Injury? Yes / No
• List Dates/Time Missed ________________________________________________
• Describe ____________________________________________________________

Were Any Diagnostic Tests Performed? (Check all that apply)
__ X-Rays  __ Bone Scan
__ MRI  __ CT-Scan  __ Other _____________________________________________

Have You Ever Been Hospitalized For a Wrist, Hand, and/or Finger Injury? Yes / No
• When? _____________________ Where? ________________________________
• Describe ____________________________________________________________

Have You Ever Had Surgery of Any Kind on Your Wrist, Hand, and/or Finger(s)? Yes / No
• When? _____________________ Surgeon? ________________________________
• Describe ____________________________________________________________
VI. Spine / Low Back / Sacroiliac Joint:

History of Spine/Low Back/Sacroiliac Joint Injury?  Yes / No

- List Dates/Time Missed ________________________________________________________
- Describe ___________________________________________________________________

Were Any Diagnostic Tests Performed? (Check all that apply)    __X-Rays    __Bone Scan
- __MRI    __CT-Scan    __Other ________________________________________________

Have You Ever Been Hospitalized For a Spine/Low Back/Sacroiliac Joint Injury?  Yes / No

- When? ___________________________    Where? ____________________________
- Describe ___________________________________________________________________

Have You Ever Had Surgery of Any Kind on Your Spine/Low Back/Sacroiliac Joint?  Yes / No

- When? ___________________________    Surgeon? ____________________________
- Describe ___________________________________________________________________

Have You Ever Had Numbness/Tingling Down One(1) or Both Legs?  Yes / No

- Dates/Time Missed? _________________________________________________________
- Describe ___________________________________________________________________

VII. Ribs / Thorax / Chest:

History of Rib/Thorax/Chest Injury?  Yes / No

- List Dates/Time Missed ________________________________________________________
- Describe ___________________________________________________________________

Were Any Diagnostic Tests Performed? (check all that apply)    __X-Rays    __Bone Scan
- __MRI    __CT-Scan    __Other ________________________________________________

Have You Ever Had Surgery for a Rib / Thorax / Chest Injury?  Yes / No

- When? ___________________________    Where? _____________________________
- Describe ___________________________________________________________________

IV. Hip / Groin:

History of Hip / Groin Injury?  Yes / No

- List Dates/Time Missed ________________________________________________________
- Describe ___________________________________________________________________

Were Any Diagnostic Tests Performed? (check all that apply)    __X-Rays    __Bone-Scan
X. Thigh (Including Quadriceps & Hamstrings):

History of Thigh Injury? Yes / No

- List Dates/Time Missed
- Describe

Were Any Diagnostic Tests Performed? (check all that apply)  

- X-Rays  
- Bone Scan  
- MRI  
- CT-Scan  
- Other

Have You Ever Had Surgery for a Thigh Injury? Yes / No

- When?  
- Where?  
- Describe

XI. Knee:

History of Knee Injury? Yes / No

- List Dates/Time Missed
- Describe

Were Any Diagnostic Tests Performed? (check all that apply)  

- X-Rays  
- Bone Scan  
- MRI  
- CT-Scan  
- Other

Have You Ever Had Surgery for a Knee Injury? Yes / No

- When?  
- Surgeon?  
- Describe

Have You Ever/Do You Presently Wear a Knee Brace?  

- Which Knee?  
- Brand/Model of Brace?  
- Reason for Wearing?
XII. Ankle / Lower Leg:

History of Ankle / Lower Leg Injury?  Yes / No

- List Dates/Time Missed _____________________________________________________
- Describe ________________________________________________________________

Were Any Diagnostic Tests Performed? (check all that apply)  __X-Rays  __Bone Scan
   __MRI  __CT-Scan  __Other ________________________________________________

Have You Ever Been Hospitalized for an Ankle / Lower Leg Injury?  Yes / No

- When? __________________________ Where? _________________________________
- Describe ______________________________________________________________

Have You Ever Had Surgery for an Ankle / Lower Leg Injury?  Yes / No

- When? __________________________ Surgeon? ______________________________
- Describe ______________________________________________________________

Do You Presently  __Tape Your Ankle(s)  __Use Ankle Brace(s)  __Other

- Describe __________________________________________________________________

XIII. Foot / Toes:

History of Foot / Toe Injury?  Yes / No

- List Dates/Time Missed _____________________________________________________
- Describe ________________________________________________________________

Were Any Diagnostic Tests Performed? (check all that apply)  __X-Rays  __Bone Scan
   __MRI  __CT-Scan  __Other ________________________________________________

Have You Ever Had Surgery for a Foot / Toe Injury?  Yes / No

- When? __________________________ Surgeon? ______________________________
- Describe ______________________________________________________________

XIV. Heat Related Problems:

Have You Ever Experienced (check all that apply):

- __ Heat Cramps:  Date(s) __________________________________________________
- __ Heat Exhaustion: Date(s) ______________________________________________
- Heat Stroke: Date(s) _____________________________________________________

Have You Ever Received Intravenous Fluids (IV) for a Heat Related Problem?  Yes / No
• Date(s) __________________________________________________________________

Have You Ever Been Hospitalized for a Heat-Related Problem?  Yes / No

• Date(s) __________________________ Where? ______________________________

XXV. Asthma:

Have You Ever Been Diagnosed with Asthma and/or Exercise Induced Asthma?  Yes / No

• Date(s) __________________________________________________________________

• Describe ________________________________________________________________

Are You Presently Taking Any Allergy Medications / Use an Inhaler?  Yes / No

• Date(s) __________________________________________________________________

• Describe ________________________________________________________________

How Many Acute Asthma Attacks Have You Had in the Past 24 Months? _______________

• Date(s) __________________________________________________________________

• Describe ________________________________________________________________

XXVI. 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

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Do You Daily Monitor Your Blood Sugar Level?  Yes / No

• Describe ________________________________________________________________

Please List Any Precautions That You Take and/or Additional Information Not Mentioned Above:

_____________________________________________________________________________

_____________________________________________________________________________

XXVII. Cardiovascular Risk Factors:

Have you ever had chest pain and/or shortness of breath during or after exercise?  Yes/No

• Describe ________________________________________________________________

Have you ever had the feeling of your heart racing or skipping beats during or after exercise?
Yes / No  Describe ________________________________________________________________

Have you felt dizzy, lightheaded, and/or passed out during or after exercise?  Yes / No
•  Describe ________________________________________________________________

Do you get tired more quickly than your teammates/friends during exercise?  Yes / No
•  Describe ________________________________________________________________

Have you ever been told you that have a heart murmur?  Yes / No
•  Describe ________________________________________________________________

Has any family member or relative died of heart problems and/or sudden death before age 35?  Yes / No
•  Describe ________________________________________________________________

Has a physician ever denied or restricted your participation in sports due to any heart problems?  Yes / No
•  Describe ________________________________________________________________

Have you ever had an electrocardiogram (EKG) of your heart?  Yes / No
•  Dates / Describe ____________________________________________________________

Have you ever been told that you have / had high blood pressure?  Yes / No
•  Describe ________________________________________________________________

Have you ever been told that you have / had high blood cholesterol?  Yes / No
•  Describe ________________________________________________________________

XVIII. 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 illnesses?
Yes / No  Have you ever been hospitalized overnight?
Yes / No  Have you ever been told by a physician to restrict your sports activity or not to participate in a sport?
Yes / No  Are you currently under a physician’s care for any medical conditions?
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  Do you take any vitamins or supplements?

Yes / No  Have you ever had a rash or hives develop during and/or after exercise?

Yes / No  Do you have any skin problems? (itching, rashes, acne, herpes, eczema, warts, fungus, or blisters)

Yes / No  Do you cough, wheeze, or have trouble breathing during or after exercise/practice?

Yes / No  Do you have only one of two paired, functioning organs? (kidney, eyes, ovary, etc.)

Yes / No  Have you ever been told that you have a kidney disease?

Yes / No  Have you had a viral infection (mononucleosis, myocarditis, etc.) within the past six (6) months?

Yes / No  Have you ever had seizures or convulsions?

Yes / No  Do you have recurrent or frequent headaches?

Yes / No  Do you have ringing in your ears or trouble hearing?

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 or greater than 10 pounds in the past year?

Yes / No  Do you want to weigh more or less than you currently do?

Yes / No  Have you ever felt forced to limit your food intake due to concerns about your weight and/or body size?

Yes / No  Have you had a history of anorexia, bulimia, and/or any other eating disorders?

Yes / No  Would you like to meet with a dietitian to discuss your nutritional needs or eating habits?

**Females Only:**

When was your first menstrual period? ______________________________________________

How many menstrual periods have you had within the past 12 months? _________________
If you have answered **YES** to any of the above, explain: ____________________________________________

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I, the undersigned, hereby acknowledge, affirm, and represent that all statements on pages one (1) through ten (10) are true and accurate to the best of my knowledge; and that 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 fully understand that **SUNY Potsdam**, its agents, servants, trustees, and employees disclaim liability, and will not be held liable for any injuries and/or illnesses not noted.

__________________________________________  __________________________
Student-Athlete Signature                      Date

__________________________________________
Student-Athlete Print Name

__________________________________________  __________________________
Parent/Guardian Signature (if under 18 years of age) Date

__________________________________________
Parent/Guardian Print Name