State University of New York at Potsdam Athletic Training Department

Student-Athlete Health History Questionnaire

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.

*Please print clearly in **BLUE or BLACK INK ONLY***

Name _____ DOB _____ Date _____

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

__MRI __CT-Scan __Other _____

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

- When? _____ Where? _____
- Describe _____

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 Been Hospitalized for a Thigh Injury?Yes / No

- When? _____ Where? _____
- Describe _____

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? Yes / No

- 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? _____

XV. 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 _____

XVI. 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

Medication	Form	Dosage	Frequency

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:

_____

_____

XVII. 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: _____

_____

_____

_____

_____

_____

_____

_____

_____

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