

Adelphi University
Athletic Training Department
Medical History Questionnaire

In order to be cleared for participation, every athlete must complete this health history questionnaire, insurance information form, and have a physical assessment by Health Services on campus. The contents of this form will be kept confidential.

Date: _____

Name: _____ S.S # _____ Student ID# _____

Date of Birth: _____ Class: Fr. So. Jr. Sr. Grad. Sport(s) _____

Home Address: _____ City: _____ State: _____ Zip: _____

Local/Campus Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Local/Cell Phone: _____ Email: _____

Medical History: Please read all questions carefully and respond by circling answers in the left margin.

- YES NO 1. Have you ever passed out or become extremely dizzy while exercising?
YES NO 2. Have you ever developed chest pain while exercising?
YES NO 3. Do you get tired more quickly than your friends do during exercise?
YES NO 4. Have you ever been told that you have a heart murmur?
YES NO 5. Have you ever had racing of your heart or skipped beats?
YES NO 6. Did you ever have any heart problems as a child?
YES NO 7. Has a physician ever denied or restricted your participation in sports for any heart problems?
YES NO 8. Do you currently, or did you ever have, asthma?
YES NO 9. Do you cough frequently after exercise?

Have you ever been told that you have or had one of the following?

- YES NO 10. Sickle Cell Trait
YES NO 11. High blood pressure
YES NO 12. Diabetes (high blood sugar)
YES NO 13. High Cholesterol
YES NO 14. Anemia (low blood count)
YES NO 15. Low iron
YES NO 16. Liver disease or hepatitis
YES NO 17. Epilepsy or seizures
YES NO 18. Bladder infections, kidney infections/stones, or other kidney diseases
YES NO 19. Blood in your urine
YES NO 20. Mononucleosis (Mono) When? _____
YES NO 21. Any significant illness not noted above? If so, specify _____

YES NO 22. Have you ever become ill from exercising in the heat?
YES NO 23. Do you have problems with muscle cramps with exercise?

YES NO 24. Have you ever had an operation? Type and date _____

YES NO 25. Are you missing one of any paired organ?
Eyes _____ Kidneys _____ Ovaries (females) _____ Lungs _____ Testes (males) _____

Please list any medications you are currently taking (including birth control pills)

YES NO 26. Have you ever had a bad reaction or are you allergic to any medication? If yes, list the medications and reaction you had to them _____

YES NO 27. Are you allergic to any insect bites or stings?

YES NO 28. List any other allergies _____

YES NO 29. Do you feel stressed out?

YES NO 30. Have you ever seen anyone for depression or a stress-related problem?

Personal Habits

YES NO 31. Do you drink alcohol? If yes, How much? _____
How often? _____

YES NO 32. Do you use tobacco products? If yes, How much? _____
How often? _____

YES NO 33. Do you use any performance-enhancing drugs? If yes, which ones? _____

YES NO 34. Do you use any recreational drugs other than alcohol or tobacco? If yes, which ones _____

Nutrition

38. How many meals a day do you generally eat? _____

39. How many snacks a day do you generally eat? _____

YES NO 40. Are there certain food groups you refuse to eat (meat, dairy, etc) _____

YES NO 41. Do you have food allergies? If so, please list _____

YES NO 42. Do you take any vitamin, mineral, or nutritional supplements? Please list _____

YES NO 43. Would you like to change your current weight? If so, what would you like to weigh?

YES NO 44. Have you ever used any technique other than diet to control your weight?

YES NO 45. Have you ever been diagnosed with an eating disorder?

Females

46. How often do you get menstrual periods (every two weeks, every month, every two months, etc). _____

47. How many days do they last? _____

YES NO 48. Have you ever seen a medical professional because of irregular periods?

Family History

YES NO 49. Has anyone to whom you are blood-related died suddenly before the age of 50?

YES NO 50. Has anyone in your family been diagnosed with Marfan's Syndrome?

YES NO 51. Do you have any family members who have sickle cell disease?

YES NO 52. Are there any medical problems in your immediate family (parents, siblings)? Please specify

YES NO 53. Has anyone in your family had a problem with drug or alcohol abuse?

Eyes, Ears, Dental

Have you experienced or do you use any of the following?

YES NO 54. Complete or near complete loss of vision in either eye (not just needing glasses)

YES NO 55. Hearing loss in either ear

YES NO 56. Broken bones in the face. Please specify _____ Surgery? _____

YES NO 57. Glasses and/or contacts.

Head

YES NO 58. Have you ever had a concussion? If yes, how many? _____

YES NO 59. Have you ever had prolonged headaches, nausea, blurred vision, or difficulty concentrating after a head injury?

Have you ever had any of the following?

YES NO 60. Surgery on your head (not just stitches)

YES NO 61. Very frequent or severe headaches

YES NO 62. Fainting spells

YES NO 63. Seizures

Neck

Have you ever had any of the following?

YES NO 64. Strained or sprained neck

YES NO 65. Fractured (broken) neck

YES NO 66. Pinched nerve, stinger, or burner

YES NO 67. Whiplash

YES NO 68. Neck surgery

Bones and Joints

YES NO 69. Have you had a fracture (broken bone) in the past three years?

YES NO 70. Have you had any stress fractures in the past? What part of the body? _____

YES NO 71. Do you have a pin, screw, or plate in your body as a result of bone or joint surgery?

YES NO 72. Do you currently have any incompletely healed injuries (fractures, strains, or sprains)?

Please specify _____

Shoulder

Have you had any of the following shoulder problems that have made you stop competing or training?

YES NO 73. Dislocation or subluxation (shoulder popped out)

YES NO 74. Rotator cuff strain, tendinitis, bursitis, or impingement

YES NO 75. Shoulder (AC joint) separation

YES NO 76. Shoulder surgery. Please specify, include date _____

Elbow

Have you had any of the following elbow problems that has made you stop competing or training?

YES NO 77. Pain, sprains, strains, or tendinitis

YES NO 78. Dislocation

YES NO 79. Fractures

YES NO 80. Elbow surgery. Please specify, include date _____

Wrist and Hand

Have you had any of the following wrist/hand problems that has made you stop competing or training?

- YES NO 81. Sprain or strain
- YES NO 82. Fracture (broken wrist, hand, or finger)
- YES NO 83. Dislocation (fingers)
- YES NO 84. Wrist or hand surgery. Please specify, include date_____

Back

Have you had any of the following back problems that have made you stop competing or training?

- YES NO 85. Low back sprain or strain
- YES NO 86. Scoliosis
- YES NO 87. Disc injury
- YES NO 88. Pain shooting down the leg
- YES NO 89. Kidney injury
- YES NO 90. Stress fracture, spondylolysis, or spondylolisthesis
- YES NO 91. Back surgery. Please specify, include date_____
- YES NO 92. Have you recently been experiencing any back pain?

Hip

Have you had any of the following hip problems that have made you stop competing or training?

- YES NO 93. Sprain or strain
- YES NO 94. Labral tear
- YES NO 95. Fracture in or around the hip
- YES NO 96. Hip surgery. Please specify, include date_____
- YES NO 97. Groin pain
- YES NO 98. Do you currently have any hip or groin pain?

Knee

Have you had any of the following knee problems that have made you stop competing or training?

- YES NO 99. Sprain or ligament injury
- YES NO 100. Cartilage (meniscus) injury
- YES NO 101. Fracture in or around the knee
- YES NO 102. Knee surgery. Please specify, include date_____
- YES NO 103. Do you experience pain, grating, or popping around the kneecap?
- YES NO 104. Do you currently have any pain in or around your knee?

Leg, Ankle, and Foot

Have you had any of the following problems that have made you stop competing or training?

- YES NO 105. Shin splints
- YES NO 106. Sprain
- YES NO 107. Dislocation
- YES NO 108. Fracture
- YES NO 109. Plantar fasciitis or heel spur
- YES NO 110. Leg, ankle, or foot surgery. Please specify, include date_____
- YES NO 111. Do you currently have any leg ankle, or foot pain?

All of the above information is accurate and complete to the best of my knowledge.

Signature of athlete _____ **Date** _____

**Adelphi University
Athletic Training Department**

Every Adelphi student athlete **must** have this form completed. Please read the following statements and sign:

Injury Reporting

As a student-athlete at Adelphi University, I accept the responsibility of reporting any injury or illness that may occur both in and out of season to the athletic training room staff, including the signs and symptoms of a concussion.

Informed Consent

Injuries can and do occur during athletic practice and competition. Such injuries can result in, but are not limited to, temporary or permanent disability, paralysis, or death to you or your opponent. These injuries may occur with or without any intent to violate any rules of specific events. All such injuries cannot be prevented.

I have read the above injury reporting statement and informed consent and understand that injuries can and do occur during athletic participation.

Signature of athlete _____ Date _____

Helmet Warning

Lacrosse, Baseball, and Softball

Do not use your helmet to butt, ram, or spear an opposing player or use your helmet as a weapon. This is a violation of the rules and can result in severe head, brain, or neck injuries, paralysis, or death to you or your opponent.

There is a risk that these injuries may also occur as a result of accidental contact without intent to butt, ram, or spear another player. No helmet can prevent all such injuries.

I have read the above helmet warning and understand that injuries can and do occur during athletic participation.

Signature of athlete _____ Date _____