



Fayetteville State University Sports
Medicine Questionnaire

PERSONAL INFORMATION:

PLEASE PRINT CLEARLY AND LEGIBLY

Name: _____
Last First Middle

SSN: _____ Banner/Student ID#: _____

Sex (Circle One): Male Female Date of Birth (mm/dd/yy): _____

Sport: _____ Eligibility (circle one): Fr So Jr Sr Grad

Address (at school): _____
Street City/State Zip Code

Phone Number: Home-() Cell-()

Permanent Address (Parent/Guardian):

Street City/State Zip Code

Emergency Contacts (MUST LIST AT LEAST ONE)

Name: _____ Phone (home): _____

Relation: _____ (work): _____

Name: _____ Phone (home): _____

Relation: _____ (work): _____

MEDICAL INFORMATION

Special Medical Information (Medications, Allergies, Medic Alert, etc...)

Physical Examination Consent

I, the above named athlete, do hereby consent to having a physical examination by a qualified physician for the express purpose of obtaining medical clearance to participate in organized athletics at Fayetteville State University.

I understand such an examination is a requirement of any and all students prior to participation in intercollegiate athletics.

I also understand that all medical records pertaining to my participation at Fayetteville State University are confidential, and cannot be released outside the athletic department without my prior written approval.

Athlete Signature: _____

Date: _____

Fayetteville State University
Sports Medicine

Shared Responsibility for Sport Safety

Participation in sports requires an acceptance of risk of injury. Student-athletes rightfully assume that those who are responsible for the conduct of the sport have taken reasonable precautions to minimize the risk of significant injury. Periodic analysis of injury patterns continuously leads to refinements in the rules and/or other safety guidelines.

However, to legislate safety via the rule book and equipment standards alone, while often necessary, is seldom entirely effective. To rely on officials to enforce compliance with the rule book is an insufficient as to rely on warning labels to produce behavioral compliance with safety guidelines. Compliance implies respect on everyone's part (student-athlete, coach, athletic trainer, physician, athletic director) for the intent and purpose of the rules and guidelines.

Student-athletes, for their part, should comply with and understand the rules and standards that govern their sports. Coaches should appropriately acquaint the student-athlete with risks of injury and with the rules and practices they are employing to minimize the student-athlete's risk of significant injury while pursuing the many benefits of the sport. The athletic trainer and team physician are also partly responsible for developing injury-prevention strategies (where possible) and the care of those injuries that occur. The athletics program, via the athletic director and coaches, should be responsible for providing a safe environment. The student-athlete and the athletics program have a mutual need for an informed awareness for the risks being accepted and for sharing the responsibility for minimizing those risks. your signature below indicates that you understand this shared responsibility process, including the role, you play in attempting to prevent injuries to yourself, your teammates and your opponents.

Signature of athlete/and parent if athlete is under age 18

Date

Assumption of Risk

I understand that while I am participating in intercollegiate athletics, there is a risk of injury. I understand that there is always the possibility of injuries when you place extra demands on the muscles, bones, joints, and ligaments in a competitive environment. Injuries that can occur in varsity athletics include by are not necessarily limited to the following: blisters, muscle strains, ligament and joint sprains, joint soreness, abrasions, contusions, stress fractures, broken bones, head, neck and spinal cord injuries involving paralysis and even death. However, if you exercise care for your safety and the safety of your teammates and your opponents, the likelihood of such injuries can be greatly reduced.

I hereby accept and assume the risk of injury and understand the possible consequences of such injury.

Signature of athlete/and parent if athlete is under age 18

Date

Consent for Treatment

I understand that I may be injured while participating in intercollegiate athletics at Fayetteville State University. I authorize the school to obtain, through a physician of its choice, any emergency care that may become necessary while participating in or traveling under Fayetteville State University's intercollegiate athletics program. I also authorize the University athletic team physician and athletics trainers to administer those treatments as necessary.

Signature of athlete/and parent if athlete is under age 18

Date

Heights (in.) _____ Weight (lbs.) _____

GENERAL MEDICAL HEALTH HISTORY

Do you CURRENTLY have any of the following SYMPTOMS or PROBLEMS?:

	YES	NO		YES	NO
Frequent Headaches			Abdominal Pain		
Visual Changes			Muscle Cramps		
Ringing in Ears			Frequent Nausea		
Sore Throats			Frequent Vomiting		
Sinus Congestion			Frequent Diarrhea		
Breathing Difficulty			Rectal Bleeding		
Recurring Coughing			Unusual Fatigue		
Chest Pain			Trouble Sleeping		

INTERNAL

Were you born with a complete and functional set of paired organs (eyes, ears, kidneys, ovaries/testicles, lungs)? Yes No

If not, which organs were involved? _____

CARDIAC	YES	NO
Have you ever felt dizzy, light-headed or passed out during or after exercise?		
Have you ever had chest pain while exercising?		
Have you ever had irregular heart beats or heart palpitations?		
Have you ever been told you have a heart murmur?		
Have you ever been seen by a heart specialist (cardiologist)?		
If yes, Who: _____ Date: _____		
Have you ever had an echo-cardiogram?		
Have you ever had a stress (heart) exam?		
Do you have a history of heart disease in your family?		
If yes, Who: _____		

VISION	YES	NO
Have you ever been to an eye doctor?		
Do you wear glasses now?		
If yes, Reading Only		
Distance Only		
All the time		
Do you wear contacts lenses?		
If yes, Soft lenses		
Hard lenses		
Do you have a second pair?		
Do you wear contact lenses/glasses to participate?		
Have you ever had an eye injury?		
Is your color vision normal?		
Have you ever worn a false eye?		
DENTAL	YES	NO
Do you have a bridge or false teeth?		
Have you ever fractured a tooth?		
Have you had a tooth knocked out?		
Do you wear a mouth protector?		

Date of last visit:

Physician's name:

Rx: R _____ L _____

Rx: R _____ L _____

COMMENTS

HEAT – Have you ever experienced any of the following?	YES	NO
Trouble with dehydration (Excessive loss of salt and water)		
Heat Stroke		
Heat Cramps (Due to fluid loss because of excessive heat)		
Heat Intolerance		

GENERAL MEDICAL HEALTH HISTORY (Continued)

ALLERGIES – Are you allergic to...?	YES	NO		YES	NO
Aspirin			Insect Bites/Stings		
Codeine			Tetanus Antitoxin or Serums		
Cortisone			Nail Polish or Cosmetics		
Sulfa			Any Foods:		
Anti-Inflammatory			Any Other Drug:		
Penicillin			Other:		
Hay Fever					

DRUG, FOOD SUPPLEMENTS AND MISCELLANEOUS AGENTS

Check the appropriate space according to YOUR use of the following items:

	Never	Rarely	Occasionally	Frequently
Vitamins				
Diet Pills				
Sleeping Pills				
Laxatives				
Alcoholic Beverages				
Antihistamines				
Anti-Inflammatory				
Caffeine				
Tobacco				
Ergogenic Supplements				
Other				

MISCELLANEOUS – Have you ever ?	YES	NO		YES	NO
Worn hearing aids			Do you have any pins, staples or wires in any part of your body?		
Stuttered or stammered					
Coughed up blood			Had any illness other than those already noted		
Bled excessively after injury					
Been advised to have any operations			Missed a game because of illness		

**FOR FEMALE ATHLETES ONLY, MALES PROCEED TO NEXT PAGE
WOMEN'S HEALTH HISTORY**

	YES	NO
Are your periods regular?		
Age of Onset: _____		
Date of last period: _____		
Interval between periods: _____		
Duration of period: _____		
Is flow heavy?		
Heavy bleeding ever a problem?		
Do you have bleeding between periods?		
Do you experience any unusual discharge?		
Are cramps a frequent problem during your period?		
Any past pregnancies/births?		
Are you on birth control medication?		
Do you use a birth control device?		
Do you do breast self examination?		
Have you ever had a gynecological exam?		
Have you ever had an eating disorder?		
Have you ever experienced an absence of your period?		

Comments:

If yes, what brand name:
If yes, explain:
If yes, date of last exam:
If yes, date of last:

Explain any "Yes" answers below.

ORTHOPAEDIC HISTORY QUESTIONNAIRE
PLEASE PLACE A CHECK IN EITHER THE YES OR NO BOX,IF YOU HAVE QUESTIONS OR
UNCERTAINTIES, PLEASE ASK ANY MEDICAL PERSONNEL FOR ASSISTANCE
HAVE YOU EVER INJURED OR CONSULTED A DOCTOR ABOUT ANY INJURY TO THE . . .

HEAD	YES	NO	DATE	COMMENTS & EXPLANATIONS
1. Have you ever experienced a head injury?				
2. Have you ever had a concussion? If so, how many and when?				
3. Do you ever get dizzy or experience headaches when you play?				
4. Any other conditions which required a physician visit?				
NECK	YES	NO	DATE	COMMENTS & EXPLANATIONS
1. Have you ever experienced a neck injury? If yes, please explain.				
CHEST WALL	YES	NO	DATE	COMMENTS & EXPLANATIONS
1. Have you ever experienced a chest wall injury (clavicle, ribs), if yes, please explain.				
LOWER BACK	YES	NO	DATE	COMMENTS & EXPLANATIONS
1. Have you ever injured your lower back? If yes, please explain.				
SHOULDERS	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you ever injured either shoulder? If yes, please explain.				
UPPER ARM/FOREARM	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you ever injured either upper arm/forearm? If yes, please explain.				
ELBOWS	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you ever injured either elbow? If yes, please explain.				
WRISTS	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you ever injured either wrist? If yes, please explain.				
HANDS/FINGERS	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you injured your hands or fingers? If yes, please explain.				
PELVIS/HIPS	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you ever injured your pelvis or hips? If yes, please explain.				

THIGHS	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you injured either thigh? If yes, please explain.				
LOWER LEGS	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you ever injured your lower legs? If yes, please explain.				
KNEES	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you ever injured either knee before? If yes, please explain.				
ANKLES	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you ever injured either ankle? If yes, please explain.				

FEET/TOES	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you ever injured your feet or toes? If yes, please explain.				

	YES	NO
Have you had or do you have any other medical problems or injuries not listed on this form?		
Do you have any medical or health problems that you are currently receiving medical treatment for?		
Have you ever been advised by a doctor not to participate in athletics?		
Are there any additional health problems you would prefer to discuss privately with our team physician?		

If any of the first four questions above were answered with YES, please explain below:

List any special equipment you require or would like to have provided:

ATHLETIC TRAINER AND/OR PHYSICIAN REVIEW COMMENTS:

The undersigned herewith,

- A. Understands that any medical expense incurred due to the above pre-existing conditions and not directly attributable to the athletic participation at Fayetteville State University is their personal responsibility.
- B. Understands that the athletic medical insurance is secondary coverage and does not cover them until he or she has been cleared by an athletic physical examination.
- C. Understands that he or she must refrain from practice while ill or injured, whether or not receiving medical treatment, and during medical treatment until he or she is discharged from treatment or is given permission by the clinical practitioner to restart participation despite continuing treatment.
- D. Understands that having passed the physical examination does not necessarily mean that he or she is physically qualified to engage in athletics, but only that the evaluator did not find a medical reason to disqualify him or her at the time of said examination.
- E. Certifies that the answers above are correct and true.

Athlete Signature _____ **Date** _____

Upon Completion of the History Form, it is to be reviewed and signed by a Staff Athletic Trainer.

Signature _____ **ATC** **Date** _____