





If yes, Left or right? \_\_\_\_\_  
Please describe with dates. \_\_\_\_\_

4. jammed, dislocated, or fractured any of the bones in your hands or fingers? Yes No  
If yes, Left or Right? \_\_\_\_\_ Which finger(s)? \_\_\_\_\_  
Please describe \_\_\_\_\_

5. injured your back? Yes No  
If yes, please describe with dates. \_\_\_\_\_

If you were you treated for this back injury by a physician or chiropractor, please list the type of treatment received, the type of provider, and dates.

### Lower Extremities

Have you ever:

1. injured either hip? Yes No  
If yes, Left or Right? \_\_\_\_\_  
Please describe with dates. \_\_\_\_\_

2. "pulled" either hamstring? Yes No  
If yes, Left or Right? \_\_\_\_\_ How many times? \_\_\_\_\_

3. injured the meniscus or cartilage in either knee? Yes No  
If yes, Left or Right? \_\_\_\_\_ Lateral or medial? \_\_\_\_\_  
Please describe including surgery and dates. \_\_\_\_\_

4. injured the ligaments in either knee? Yes No  
If yes, Left or Right? \_\_\_\_\_  
Please describe injury, physician, treatment and dates. \_\_\_\_\_

Please give the date (or anticipated date) you were or will be released for athletic participation. \_\_\_\_\_

5. had other problems with your knees or surrounding structures? Yes No  
If yes, please describe with dates \_\_\_\_\_

6. had shin splints or a stress fracture in the lower leg? Yes No  
If yes, please describe with dates \_\_\_\_\_

7. had compartment syndrome in the lower leg? Yes No  
If yes, please describe with dates \_\_\_\_\_

7. injured your ankle? Yes No  
If yes, Left or Right? \_\_\_\_\_  
Please describe treatment with dates \_\_\_\_\_

8. Do you get your ankles taped for athletic participation? Yes No

9. Have you ever had an injury to either foot? Yes No

If yes, Left or Right? \_\_\_\_\_  
Please describe and with dates \_\_\_\_\_

### **Eyes - Ears - Dental**

1. Do you wear glasses?  
If yes, do you wear them during athletics? Yes No
2. Do you wear contacts? What type? \_\_\_\_\_  
Do you wear them during athletics? Yes No
3. When was your last eye examination? If you don't know put "Unknown" \_\_\_\_\_  
Please list any visual problems found. \_\_\_\_\_
4. Do you have a hearing impairment?  
If yes, which side and please describe \_\_\_\_\_
5. Do you wear any dental appliances? Please circle all that apply  
Braces    Permanent Bridge    Crown    Partial    Caps    False Teeth    Full Plate

### **General**

1. Have you had any other operations or surgeries, other than those listed above, in the past three years?  
If yes, please describe with dates \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. Have you had any additional illnesses or injuries during the past three years?  
If yes, please describe with dates. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Have you ever been advised by a physician not to participate in any form of athletics?  
If yes, please describe the reason with dates (including dates of clearance). \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Have you ever experienced heat cramps, heat exhaustion, or heat stroke.  
If yes, please list the condition, describe the events and treatment, dates including where they occurred, and any hospitalization required. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Is there any health or medical related problem that you feel needs to be disclosed in order to provide the best health care possible?  
If yes, please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **Family History**

**Have any of your blood relatives (grandparents, parents, siblings, children):**

- a) had/have cardiovascular disease Yes No  
If yes, list relationship \_\_\_\_\_
- b) died suddenly due to cardiovascular disease Yes No  
If yes, list relationship \_\_\_\_\_
- c) had/have Marfan's Syndrome Yes No  
If yes, list relationship \_\_\_\_\_
- d) had/have hypertrophic cardiomyopathy Yes No  
If yes, list relationship \_\_\_\_\_
- e) had/have an enlarged heart Yes No  
If yes, list relationship \_\_\_\_\_
- f) had/have diabetes Yes No  
If yes, list relationship \_\_\_\_\_
- g) had/have sickle cell anemia or the sickle cell trait Yes No  
If yes, list relationship \_\_\_\_\_
- h) had/have any other significant medical Yes No  
problem (ex: cancer, hypertension, etc)  
If yes, list relationship \_\_\_\_\_

**Female Athletes**

**All information is confidential**

1. Does your menstrual cycle occur: (monthly, twice a month, other). Please circle  
Please specify any irregularities: \_\_\_\_\_
- Yes No
2. Have you ever missed more than three consecutive menstrual periods at any time?
- Yes No
3. Have you ever missed your menstrual period for six consecutive months.  
Number of months missed \_\_\_\_\_
- Yes No
4. Are you currently using birth control pills?
- Yes No
5. Have you ever had a breast examination? Date of last exam \_\_\_\_\_
- Yes No
6. Have you ever had a PAP smear? Date of last exam \_\_\_\_\_
- Yes No
7. Has a physician ever diagnosed you with anorexia nervosa or bulimia? Please circle

**PHYSICAL EXAM AND MEDICAL HISTORY STATEMENT**

I have had a complete physical examination on \_\_\_\_\_. I have completed a medical history questionnaire to the best of my knowledge and have discussed with the ISU team physicians and/or consultants my prior medical history as well as all existing complaints, injuries, ailments, and symptoms. All of my questions concerning this medical history and my condition have been answered to my satisfaction. I also affirm that I do not suffer from any disability, injury, condition, complaint, or problem that I have NOT DISCLOSED on any such forms and/or have not discussed with the team physicians and/or consultants. Also, I recognize the importance of fully and accurately disclosing my physical condition, past and present with the Illinois State University medical staff and/or consultants.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### Catastrophic Injury Statement

The possibility of sustaining a catastrophic injury is inherent in any athletic activity. I, \_\_\_\_\_, understand that by participating in athletics at Illinois State University the potential of a catastrophic injury does exist. With this fact in mind, I understand the importance of rules and procedures as well as the necessity of using proper techniques. Furthermore, I understand that the possibility of a catastrophic injury does exist though the above are followed to the fullest.

Additionally, I understand that participating in athletics during times of extreme heat and/or humidity can be dangerous and/or fatal. Protective padding, such as (but not limited to) helmets and shoulder pads, can increase the risk for heat related illness, injury, and/or death. **Heat related injury, illness, and/or death is a risk for ALL sports, not exclusive to football.**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### Authorization to Treat and Care

I give authorization to the athletic training staff and/or medical consultants to evaluate and treat my injuries that occur during my participation in athletics at Illinois State University. I understand the team physicians have the authority to eliminate me from further participation because of an injury, illness, medical condition, and/or because of an undue liability risk to Illinois State University.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

I agree that I will inform the Athletic Training Staff immediately if there is a change to my medical condition and/or if I begin taking medication, supplements, vitamins, and/or herbal remedies. I understand that withholding this information may result in improper medical treatment and endanger my health.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

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**ALL THE QUESTIONS IN THIS MEDICAL HISTORY FORM HAVE BEEN ANSWERED COMPLETELY AND TRUTHFULLY TO THE BEST OF MY KNOWLEDGE.**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Parent or Legal Guardian Signature **ONLY** if the Student Athlete is under 18 years of age

Date: \_\_\_\_\_ Signature: \_\_\_\_\_