# UNIVERSITY OF MARYLAND SPORTS MEDICINE DEPARTMENT

## Student-Athlete Health History Questionnaire Form

The information contained in this medical history form will only be used by the Sports Medicine Department of the University of Maryland 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 ______________________________ Date ______________

Social Security # ______________________ Date of Birth ______________________

Race: ☐ Caucasion ☐ Afro-American ☐ Hispanic ☐ Asian/Pacific ☐ Alaskan/Indian ☐ Other ____________

Sport(s) ______________________ Position(s) ______________________

Height ____________ Weight ______________ ☐ Right Handed ☐ Left Handed

**PERMANENT ADDRESS:**

______________________________
STREET

______________________________
CITY STATE ZIP CODE

______________________________
PHONE 1 PHONE 2 (CELLULAR)

Father's Name ______________________________ Age ____________

If Deceased, Cause of Death ______________________ Age @ Death ____________

Father's Occupation ______________________

Address *(if different from permanent address):*

______________________________
STREET

______________________________
CITY STATE ZIP CODE

______________________________
HOME PHONE WORK PHONE

Mother's Name ______________________________ Age ____________

If Deceased, Cause of Death ______________________ Age @ Death ____________

Mother's Occupation ______________________

Address *(if different from permanent address):*

______________________________
STREET

______________________________
CITY STATE ZIP CODE

______________________________
HOME PHONE WORK PHONE



**Student-Athlete's Initials** ____________

## I. Cardiovascular Risk Factors:

Have you ever had chest pain and/or shortness of breath during or after exercise / practice? ☐ YES ☐ NO

- Please Describe ____________

Have you ever felt dizzy, lightheaded, and/or passed out during or after exercise / practice? ☐ YES ☐ NO

- Please Describe ____________

Have you ever had the feeling of your heart racing or skipping beats during or after exercise / practice? ☐ YES ☐ NO

- Please Describe ____________

Do you get tired more quickly than your teammates / friends do during exercise / practice? ☐ YES ☐ NO

- Please Describe ____________

Have you ever been told that you have a heart murmur? ☐ YES ☐ NO

- Please Describe ____________

Has any family member or relative died or heart problems and/or of sudden death before age 50? ☐ YES ☐ NO

- Please Describe ____________

Has a physician ever denied or restricted your participation in sports due to any heart / cardiovascular problems? ☐ YES ☐ NO

- Please Describe ____________

Have you ever had an electrocardiogram (EKG) and/or echocardiogram (ECHO) of your heart? ☐ YES ☐ NO

- Dates / Please Describe ____________

Does anyone in your family have a history of high blood pressure? ☐ YES ☐ NO

- Please Describe ____________

Have you ever been told that you have / had high blood pressure? ☐ YES ☐ NO

- Please Describe ____________

Does anyone in your family have a history of high blood cholesterol? ☐ YES ☐ NO

- Please Describe ____________

Have you even been told that you have / had high blood cholesterol? ☐ YES ☐ NO

- Please Describe ____________

## II. Allergies:

Have You Ever Been Diagnosed With Seasonal Allergies? ☐ YES ☐ NO

- Please Describe ____________

Are You Presently Taking/Have You Previously Taken Any Allergy Medications? ☐ YES ☐ NO

- Please Describe ____________

Are you allergic to and/or ever had an unfavorable / allergic reaction to any medications? ☐ YES ☐ NO

- Please Describe ____________

Are you allergic to and/or ever had an unfavorable / allergic reaction to any food items? ☐ YES ☐ NO

- Please Describe ____________

Are you allergic to and/or ever had an unfavorable / allergic reaction to bee stings, insect bites, etc.? ☐ YES ☐ NO

- Please Describe ____________



**Student-Athlete's Initials** ____________

## III. Asthma:

Have You Ever Been Diagnosed With Asthma and/or Exercised Induced Asthma? ☐ YES ☐ NO

- Date(s)? ______
- Please Describe ______

Are You Presently Taking / Have You Previously Taken Any Asthma Medications / Use an Inhaler? ☐ YES ☐ NO

- Date(s)? ______
- Please Describe ______

How Many Times Do You Use Your Rescue Inhaler (e.g. Albuterol, Proventil, etc.) During An Average Week? ______

How Many Acute Asthma Attacks Have You Had In The Past 12 Months? ______

- Date(s)? ______
- Please Describe ______

Have You Ever Been Hospitalized As a Result of Asthma and/or Exercised Induced Asthma? ☐ YES ☐ NO

- Date(s)? ______
- Please Describe ______

Have You Ever Been Advised Not To Participate In Athletic Activities Due To Asthma Or Any Related Condition? ☐ YES ☐ NO

- Please Describe ______

## IV. Head Injuries / Concussion:

Have You Ever Suffered A Head Injury / Concussion (no matter how minor)? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______
- Please Describe ______

Have You Ever Been Evaluated By A Doctor For A Head Injury / Concussion? ☐ YES ☐ NO

- Please Describe ______

Were Any Diagnostic Tests Performed? ☐ YES ☐ NO (check all that apply)

☐ X-ray ☐ MRI ☐ CT-Scan ☐ Neuropsychological Testing ☐ Other ______

Have You Ever Been Hospitalized, Knocked Out, Become Unconscious, and/or Lost Your Memory Due To A Head Injury / Concussion?
☐ YES ☐ NO

- Please Describe ______

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Head Injury / Concussion? ☐ YES ☐ NO

- Please 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 ______ Please Describe ______
- Medications Taken for Migraines? ______

Have You Had Headaches For More Than Three (3) Months? ☐ YES ☐ NO

- If yes, please explain ______



**Student-Athlete's Initials** ______

## V. Eye:

When Was Your Last Eye Exam? ______________________

- Findings? ______________________

Have You Ever Suffered An Injury To Your Eye(s) and/or Been Advised That You Have An Eye Disease? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______________________
- Please Describe ______________________

Were Any Diagnostic Tests Performed? ☐ YES ☐ NO (check all that apply)

☐ X-ray ☐ MRI ☐ CT-Scan ☐ Other ______________________

Have You Ever Been Hospitalized and/or Seen An Ophthalmologist For An Eye Injury? ☐ YES ☐ NO

- Please Describe ______________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Eye Injury? ☐ YES ☐ NO

- Please Describe ______________________

Do you routinely suffer from blurred vision, double vision, tunnel vision, and/or any other abnormal sight? ☐ YES ☐ NO

- Please Describe ______________________

Do you routinely wear glasses? ☐ YES ☐ NO

Do you routinely wear contact lenses? ☐ YES ☐ NO Type ______________________

Do you require any special devices / equipment? ☐ YES ☐ NO Type ______________________

## VI. Ear / Nose / Throat:

Have You Ever Suffered An Injury To Your Ear(s), Nose, and/or Throat? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______________________
- Please Describe ______________________

Were Any Diagnostic Tests Performed? ☐ YES ☐ NO (check all that apply)

☐ X-ray ☐ MRI ☐ CT-Scan ☐ Other ______________________

Have You Ever Been Hospitalized For A Ear, Nose, and/or Throat Injury? ☐ YES ☐ NO

- Please Describe ______________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Ear, Nose, and/or Throat Injury? ☐ YES ☐ NO

- Please Describe ______________________

## VII. Dental:

When Was Your Last Dental Exam? ______________________

- Findings? ______________________

Have You Ever Suffered An Injury To Your Mouth, Jaw, and/or Teeth? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______________________
- Please Describe ______________________

Were Any Diagnostic Tests Performed? ☐ YES ☐ NO (check all that apply)

☐ X-ray ☐ MRI ☐ CT-Scan ☐ Other ______________________

Have You Ever Been Hospitalized For A Mouth, Jaw, and/or Tooth Injury? ☐ YES ☐ NO

- Please Describe ______________________



**Student-Athlete's Initials** ______________

## VIII. Cervical Spine / Neck:

Have You Ever Suffered An Injury To Your Cervical Spine and/or Neck? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______
- Please Describe ______

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For A Cervical Spine / Neck Injury? ☐ YES ☐ NO

- When? ______ Where? ______
- Please Describe ______

Have You Ever Had "Burners", "Stingers", or Brachial Plexus Injuries? ☐ YES ☐ NO

- How Many? ______ Date(s)/Time Missed? ______

Have You Ever Experienced Numbness and/or Tingling in Your Arms/Fingers? ☐ YES ☐ NO

- Date(s)? ______
- Please Describe? ______

Have You Ever Had Surgery of Any Kind on Your Cervical Spine / Neck? ☐ YES ☐ NO

- When? ______ Surgeon? ______
- Please Describe ______

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Cervical Spine / Neck Injury? ☐ YES ☐ NO

- Please Describe ______

Do You Presently Wear A Neck Roll / Collar, "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 ______

## IX. Shoulder / Upper Arm:

Have You Ever Suffered An Injury To Your Shoulder / Upper Arm? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______
- Please Describe ______

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For A Shoulder / Upper Arm Injury? ☐ YES ☐ NO

- When? ______ Where? ______
- Please Describe ______

Have You Ever Had Surgery of Any Kind on Your Shoulder / Upper Arm? ☐ YES ☐ NO

- When? ______ Surgeon? ______
- Please Describe ______

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Shoulder / Upper Arm Injury? ☐ YES ☐ NO

- Please Describe ______



**Student-Athlete's Initials** ______

## X. Elbow / Forearm:

Have You Ever Suffered An Injury To Your Elbow / Forearm? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ____________________
- Please Describe ____________________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For An Elbow / Forearm Injury? ☐ YES ☐ NO

- When? ____________________ Where? ____________________
- Please Describe ____________________

Have You Ever Had Surgery of Any Kind on Your Elbow / Forearm? ☐ YES ☐ NO

- When? ____________________ Surgeon? ____________________
- Please Describe ____________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Elbow / Forearm Injury? ☐ YES ☐ NO

- Please Describe ____________________

## XI. Wrist, Hand, & Fingers:

Have You Ever Suffered An Injury To Your Wrist(s), Hand(s), and/or Finger(s)? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ____________________
- Please Describe ____________________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For A Wrist, Hand, and/or Finger Injury? ☐ YES ☐ NO

- When? ____________________ Where? ____________________
- Please Describe ____________________

Have You Ever Had Surgery of Any Kind on Your Wrist, Hand, and/or Finger(s)? ☐ YES ☐ NO

- When? ____________________ Surgeon? ____________________
- Please Describe ____________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Wrist, Hand, and/or Finger Injury? ☐ YES ☐ NO

- Please Describe ____________________



**Student-Athlete's Initials** ____________

## XII. Spine / Low Back / Sacroiliac Joint:

Have You Ever Suffered An Injury To Your Spine / Low Back / Sacroiliac Joint? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ____________________
- Please Describe ____________________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For A Spine / Low Back / Sacroiliac Joint Injury? ☐ YES ☐ NO

- When? ____________________ Where? ____________________
- Please Describe ____________________

Have You Ever Had Surgery of Any Kind on Your Spine / Low Back / Sacroiliac Joint? ☐ YES ☐ NO

- When? ____________________ Surgeon? ____________________
- Please Describe ____________________

Have You Ever Had Numbness/Tingling Down One (1) or Both Legs? ☐ YES ☐ NO

- Date(s)/Time Missed? ____________________
- Please Describe? ____________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Spine, Low Back, or SI Joint Injury? ☐ YES ☐ NO

- Please Describe ____________________

## XIII. Hip / Groin:

Have You Ever Suffered An Injury To Your Hip / Groin *(including hernias and/or sports hernias)?* ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ____________________
- Please Describe ____________________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Had Surgery For A Hip / Groin Injury? ☐ YES ☐ NO

- When? ____________________ Where? ____________________
- Please Describe ____________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Hip and/or Groin Injury? ☐ YES ☐ NO

- Please Describe ____________________



**Student-Athlete's Initials** ____________

## XIV. Thigh / Hamstring / Quadriceps:

Have You Ever Suffered An Injury To Your Thigh, Hamstring, and/or Quadriceps? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______
- Please Describe ______

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For A Thigh, Hamstring, and/or Quadriceps Injury? ☐ YES ☐ NO

- When? ______ Where? ______
- Please Describe ______

Have You Ever Had Surgery For A Thigh, Hamstring, and/or Quadriceps Injury? ☐ YES ☐ NO

- When? ______ Surgeon? ______
- Please Describe ______

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Thigh, Hamstring, or Quadriceps Injury? ☐ YES ☐ NO

- Please Describe ______

## XV. Knee / Patella:

Have You Ever Suffered An Injury To Your Knee and/or Patella (kneecap)? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______
- Please Describe ______

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For A Knee and/or Patella Injury? ☐ YES ☐ NO

- When? ______ Where? ______
- Please Describe ______

Have You Ever Had Surgery For A Knee and/or Patella Injury? ☐ YES ☐ NO

- When? ______ Surgeon? ______
- Please Describe ______

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Knee / Patella Injury? ☐ YES ☐ NO

- Please Describe ______

Have You Ever/Do You Presently Wear A Knee Brace? ☐ YES ☐ NO

- Which Knee? ______ Brand / Model of Brace? ______
- Reason for Wearing ? ______



**Student-Athlete's Initials** ______

## XVI. Ankle / Lower Leg:

Have You Ever Suffered An Injury To Your Ankle / Lower Leg? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______
- Please Describe ______

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For An Ankle / Lower Leg Injury? ☐ YES ☐ NO

- When? ______ Where? ______
- Please Describe ______

Have You Ever Had Surgery For An Ankle / Lower Leg Injury? ☐ YES ☐ NO

- When? ______ Surgeon? ______
- Please Describe ______

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Ankle / Lower Leg Injury? ☐ YES ☐ NO

- Please Describe ______

Do You Presently ☐ Tape Your Ankle(s) ☐ Use Ankle Brace(s) ☐ Other

- Please Describe ______

## XII. Foot / Toes:

Have You Ever Suffered An Injury To Your Foot / Toe(s)? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______
- Please Describe ______

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Had Surgery For A Foot / Toe Injury? ☐ YES ☐ NO

- When? ______ Surgeon? ______
- Please Describe ______

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Foot and/or Toe Injury? ☐ YES ☐ NO

- Please Describe ______

## XIII. Ribs / Thorax / Chest:

Have You Ever Suffered An Injury To Your Rib / Thorax / Chest? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______
- Please Describe ______

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Had Surgery For A Rib / Thorax / Chest Injury? ☐ YES ☐ NO

- When? ______ Where? ______
- Please Describe ______

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Ribs, Thorax, and/or Chest Injury? ☐ YES ☐ NO

- Please Describe ______



**Student-Athlete's Initials** ______

## XIX. Abdomen:

Have You Ever Been Diagnosed With A Problem With Your Stomach, Abdomen, Intestines, or Rectum? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ____________________
- Please Describe ____________________

Have You Ever Suffered An Injury To Your Abdomen? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ____________________
- Please Describe ____________________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Had Surgery For An Abdomen Injury? ☐ YES ☐ NO

- When? ____________________ Where? ____________________
- Please Describe ____________________

Do You Routinely Suffer From Severe Or Recurrent Abdominal Pain? ☐ YES ☐ NO

- Please Describe ____________________

Do you Routinely Suffer From Chronic or Recurrent Diarrhea? ☐ YES ☐ NO

- Please Describe ____________________

Do You Have Only One Of Two Paired, Functioning Organs (e.g. kidney, testicles, ovary, etc.)? ☐ YES ☐ NO

- Please Describe ____________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Abdomen Injury? ☐ YES ☐ NO

- Please Describe ____________________

## XX. Medical Testing:

Have You Ever Been Diagnosed With A Communicable Disease (e.g. STD, HIV, Hepatitis A, B, or C, Herpes Simplex, Syphyllis, Tuberculosis)?

☐ YES ☐ NO

- List Dates/Time Missed ____________________
- Please Describe ____________________

## XXI. Dermatological:

Do you have any skin problems that we should be aware of (e.g. itching, rashes, acne, warts, eczema, fungus, etc.)? ☐ YES ☐ NO

- Please Describe ____________________

Have you ever been under the care of a dermatologist for any condition? ☐ YES ☐ NO

- Please Describe ____________________

Have you ever been advised not to participate in athletic activities due to a skin condition? ☐ YES ☐ NO

- Please Describe ____________________

## XXII. Prescription Medications:

Please List **ALL** Prescription & Over-the-Counter Medications That You Are **CURRENTLY** Taking or **Have Taken** In The PAST Two (2) Years, & For What Purpose:

| MEDICATION | PURPOSE | DOSAGE | DATE(S) |
| --- | --- | --- | --- |
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## XXIII. Supplements / Ergogenic Aids:

Please List **ALL** Supplements / Ergogenic Aids That You Are **CURRENTLY** Taking or **Have Taken** In The PAST Two (2) Years, & For What Purpose:

| SUPPLEMENT | PURPOSE | DOSAGE | DATE(S) |
| --- | --- | --- | --- |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
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## XXIV. Heat Related Problems:

Have You Ever Suffered From A Heat Related Injury? ☐ YES ☐ NO (check all that apply):

- ☐ Heat Cramps- Date(s)? __________
- ☐ Heat Syncope (Fainting)- 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? __________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Heat Related Injury? ☐ YES ☐ NO

- Please Describe __________



**Student-Athlete's Initials** __________

## XXV. 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

- How Many Times Per Day? ______ What Is Your Average Level? ______

Have You Had Your A1C Level Checked Within The Last Three (3) Months? ☐ YES ☐ NO Level ______

Have You Had Any Hypoglycemic Episodes (low blood sugar) Within The Last Twelve (12) Months? ☐ YES ☐ NO

- Please Describe ______

Have You Ever Been Advised Not To Participate In Athletic Activities Due To Diabetes? ☐ YES ☐ NO

- Please Describe ______

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

______

## XXVI. Sickle Cell Anemia:

Have you ever been tested for Sickle Cell Anemia that you are aware of? ☐ YES ☐ NO

- Date? ______ Result? ______

Does any member of your family carry the Sickle Cell Trait / have Sickle Cell Anemia that you are aware of? ☐ YES ☐ NO

- Please Describe ______

Have you ever been advised that you carry the Sickle Cell Trait / have Sickle Cell Anemia? ☐ YES ☐ NO

- Please Describe ______

## XXVII. For Females Only:

At what age did you have your first menstrual period? ______

☐ YES ☐ NO Have you had menstrual periods within the past 12 months?

- If yes, how many? ______ When was your most recent menstrual period? ______
- How much time do you usually have from the start of one period to the start of another? ______
- What was the longest time between menstrual periods within the past year? ______

☐ YES ☐ NO Do you have painful or heavy menstrual periods?

☐ YES ☐ NO Do you take any medications during your menstrual periods? If yes, what? ______

☐ YES ☐ NO Do you take birth control pills? If yes, what brand? ______

☐ YES ☐ NO Have you ever had any problems with your breasts?

☐ YES ☐ NO Have you had a pelvic examination within the last year?



**Student-Athlete's Initials** ______

**XXVIII. 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 Have you ever had a rash or hives develop during and/or after exercise?
☐ YES ☐ NO Do you cough, wheeze, or have trouble breathing during or after exercise / practice?
☐ YES ☐ NO Have you ever been told that you have kidney disease?
☐ YES ☐ NO Have you ever had rubella ("German Measles") and/or Rubeola ("red measles")?
☐ YES ☐ NO Have you ever had a stomach and/or duodenal ulcer?
☐ YES ☐ NO Have you had a viral infection (i.e. mononucleosis, myocarditis, etc.) within the past six (6) months?
☐ YES ☐ NO Have you ever had seizures, convulsions, and/or epilepsy?
☐ YES ☐ NO Have you ever had gall bladder disease and/or a urinary problem?
☐ YES ☐ NO Do you have ringing in your ears or trouble hearing?
☐ YES ☐ NO Do you have frequent ear infections or nosebleeds?
☐ YES ☐ NO Have you ever had an abnormal chest x-ray and/or pneumonia?
☐ YES ☐ NO Do you require any special equipment (braces, neck rolls, dental, orthotics, hearing aids, etc.)
☐ YES ☐ NO Have you ever had the chickenpox? If yes, when? ____________________________

☐ YES ☐ NO Are you aware of any reasons why you should not participate in intercollegiate athletics at the University of Maryland at this time?
☐ YES ☐ NO Have you had a tetanus booster within the past five (5) years? If yes, when? ____________________
☐ YES ☐ NO Have you ever received the Hepatitis B (HBV) Vaccination series (all 3 shots)? If yes, when? ____________

☐ YES ☐ NO Do you smoke cigarettes, use smokeless tobacco, or use tobacco in any form?
☐ YES ☐ NO Do you use alcohol? If yes, how often? ____________________________
☐ YES ☐ NO Have you ever used / tried marijuana, cocaine, or any other illicit "street" drugs?
☐ YES ☐ NO Do you have any questions regarding drugs, tobacco, or alcohol?
☐ 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 (loss or gain) of greater than 10 pounds in the past year?
☐ YES ☐ NO Are you a vegetarian? If yes, what type? ____________________________
☐ YES ☐ NO Do you regularly lose weight to participate in your sport?
☐ YES ☐ NO Do you want to weigh more or less than you presently 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 (forced vomiting), and/or any other eating disorders?
☐ YES ☐ NO Would you like to meet with a dietitian to discuss your nutritional needs or eating habits?

If you have answered **YES** to any of the above, please explain: ________________________________________________

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**Student-Athlete's Initials** ____________

**Please describe below any further injury information, which is knowledgeable to you and not required on this form.**

I, the undersigned, hereby acknowledge, affirm, and represent that all statements on pages one (1) through fourteen (14) 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 understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

Student-Athlete Signature ____________________ Date ____________

Student-Athlete Print Name ____________________

Parent/Guardian Signature *(if under 18 years of age)* ____________________ Date ____________

Parent/Guardian Print Name ____________________

Witness ____________________ Date ____________

**Reviewed By:**

Reviewer's Signature ____________________ Date ____________

Reviewer Print Name ____________________