

**OLD DOMINION UNIVERSITY
FIRST YEAR MEDICAL HISTORY QUESTIONNAIRE
INTERCOLLEGIATE ATHLETICS**

NAME: _____	BIRTH DATE: _____
TODAY'S DATE: _____	SPORT: _____

Instructions: The below information is necessary in order for the athletic training/medical staff to have a basic knowledge of those conditions, injuries, etc. that you have had in the past or may be affecting you at present. Please read all questions carefully and respond as directed. Be as specific as possible wherever and whenever possible. The contents of this form will be kept confidential by the athletic training department and will be used as supplementary information by the examining physicians and athletic trainers.

General Medical History

1. How many years has it been since your last complete health examination, other than an exam required for participation in sports?

- 1 year 2 year 3 year >3 years
- Have never had a complete health examination other than for athletics.

2. Are you presently taking any prescribed or over the counter medication? (Including birth control pills, insulin, allergy shots or pills, asthma inhalers, epilepsy medication, anti-inflammatory medication, supplements of any kind. Etc.)

- Yes (If yes, please fill out below.)
- No

Name of Medication	Dose	Frequency of use

3. Do you have an allergy to any of the following:

	Yes	No	Specify Allergy:
drug or medicine (over the counter/ prescribed)			
foods			
insect or animals			
plants, grasses, pollen, dust, etc.			
other			

4. Has a doctor ever told you that you have/had any of the following medical problems?

	Yes	No		Yes	No
mononucleosis			stomach or intestinal ulcer		
rubella (German Measles)			hernia		
chicken pox			diabetes		
hearing defect or loss			sickle cell anemia/carrier		

	Yes	No		Yes	No
epilepsy			other anemia		
tumor, growth, cyst, cancer			abnormal bleeding or clotting disorder		
over-active thyroid			blood clot or embolism		
under-active thyroid			leukemia or other blood disorders		
arthritis			blood in urine		
Marfan syndrome			kidney injury		
other heart abnormality			other kidney disease		
oral herpes (cold sores)			frequent urinary tract infections		
genital herpes			depression		
injury to liver or spleen			other mental disorder		
hepatitis			birth defect		

5. Have you ever had surgery to any of the following:

	Yes	No	Date	If yes, reason for surgery:
eyes				
ears/nose/throat				
heart				
lungs				
stomach or bowels/appendix				
kidneys				
liver/spleen				
bone				
muscle/ligament/tendon				
joint				
other (please specify)				

6. Were you born with two normal:

	Yes	No	If no, please specify abnormality:
eyes			
ears			
kidney			

7. Do you presently have any of the following skin problems?

	Yes	No
rash		
fungal infection		
cold sore(s)		

8. Have you ever had heat exhaustion/heat stroke/sun stroke? Yes No

9. During or after exercise, have you ever:

	Yes	No		Yes	No
been dizzy or light-headed?			found it more difficult to breath than usual?		
passed out (fainted)?			had problems with coughing?		
had chest pain, discomfort or tightness?					

10. Have you ever been told that you have a heart murmur? Yes No
 --If yes, have you ever been held out of competition due to the murmur? Yes No

11. Have you ever been told by a doctor that you had or have:

	Yes	No
high blood pressure?		
pericarditis, myocarditis, endocarditis (infections of the heart)?		
rheumatic fever?		
Other heart or vascular problems? (please specify in space below)		

12. Have you ever had any medical tests for your heart (i.e. EKG, echocardiogram)?
 Yes (If yes, please specify test and reason below.)
 No

Test	Date	Reason

13. Have you ever had any of the below listed conditions?

	Yes	No		Yes	No
bronchitis			wheezing that starts during or just after exercise		
tuberculosis			pneumothorax (collapsed lung)		
asthma					

--If you have asthma, do you carry an inhaler? Yes No

14. Have you ever had a concussion?

Yes (How many times? 1x 2x 3x 4x >4x)
 No

If yes, please give details (i.e. approximate dates of each, whether rendered unconscious or not, length of time out of activity):

15. Have you ever had any long term problems due to a head injury (i.e. memory loss, headaches, seizures, lack of concentration)?

Yes No

16. Have you ever had any symptoms of numbness, tingling or weakness in your:

	Yes	No
shoulders/arms/hands?		
buttocks?		
legs/feet?		

17. Have you ever had a seizure? Yes No

18. Do you experience migraine headaches? Yes No

19. Have you ever had a serious eye injury?

Yes (If yes, please specify below.)

No

20. Do you have vision in both eyes? Yes No

21. Are you legally blind in either of your eyes? Yes No

22. Do you wear any of the following dental appliances?

	Yes	No		Yes	No
permanent bridge			full plate		
permanent crown			braces		
removable partial			other (please specify):		

23. Have you ever suffered from or are you currently suffering from Temporal Mandibular Joint Syndrome (TMJ)?

Yes No

Women Only, Men to Question #27

24. When was your most recent menstrual period?

<1 month 1-3 months 4-6 months >6 months

25. In the past 12 months:

	Yes	No
have you had trouble with heavy menstrual bleeding?		
have you had bleeding between periods?		
have you had menstrual cramps or pain which affected your school or athletic performance?		
have you had any discharge from your vagina?		
how many periods have you had? <input type="radio"/> 0 <input type="radio"/> 1-3 <input type="radio"/> 4-6 <input type="radio"/> 7-12 <input type="radio"/> >12		
what was the longest time between periods? <input type="radio"/> <1 month <input type="radio"/> 1-3 months <input type="radio"/> 4-6 months <input type="radio"/> >6 months		
on average how long has each period lasted? <input type="radio"/> 1-5 days <input type="radio"/> 6-10 days <input type="radio"/> 11-15 days <input type="radio"/> >15 days		

26. Would you like to discuss with the medical staff any gynecological problems you may have?

Yes

No

Men Only, Women to Question #29

27. Were you born with two normal testicles? Yes No

28. Have you ever had surgery to remove or repair a testicle? Yes No

Orthopedic History

Have you had within the past 3 years (Yes/No columns) or do you currently have (Now column) an injury or problem of the following:

29. NECK:

	Yes	No	Now		Yes	No	Now
disc disease				strain/sprain			
traumatic fracture				surgery			
stress fracture				burner/stinger			
whiplash				other (please specify):			
If any yes answers, please specify date, right/left, etc:							

30. SPINE/BACK:

	Yes	No	Now		Yes	No	Now
congenital deformity/birth defect				spondylolisthesis (slipped vertebra)			
traumatic fracture				disc disease			
stress fracture				sacroiliac dysfunction			
back pain				sciatica			
back stiffness				scoliosis			
spondylolysis				surgery			
other (please specify):							
If any yes answers, please specify date, right/left, etc:							

31. SHOULDER:

	Yes	No	Now		Yes	No	Now
traumatic fracture				muscle strain			
bursitis				subluxation			
acromioclavicular (AC) separation				dislocation			
tendonitis				instability			
impingement				surgery			
other (please specify):							
If any yes answers, please specify date, right/left, etc:							

32. ELBOW:

	Yes	No	Now		Yes	No	Now
traumatic fracture				muscle strain			
ligament injury				dislocation			
tennis elbow/golfer's elbow				surgery			
bursitis							
other (please specify):							
If any yes answers, please specify date, right/left, etc:							

33. HAND/WRIST/FINGERS:

	Yes	No	Now		Yes	No	Now
traumatic fracture				tendonitis			
stress fracture				ganglion			
ligament injury				dislocation			
tendon injury				surgery			
other (please specify):							
If any yes answers, please specify date, right/left, etc:							

34. PELVIS/HIP:

	Yes	No	Now		Yes	No	Now
traumatic fracture				tendonitis			
stress fracture				contusion/hip pointer			
groin strain				glenoid labrum tear			
dislocation				surgery			
other (please specify):							
If any yes answers, please specify date, right/left, etc:							

35. THIGH:

	Yes	No	Now		Yes	No	Now
traumatic fracture				hamstring strain			
stress fracture				quadriceps strain			
tendonitis				severe contusion			
bursitis				surgery			
other (please specify):							
If any yes answers, please specify date, right/left, etc:							

36. KNEE:

	Yes	No	Now		Yes	No	Now
meniscal injury				catching, giving way, instability feeling			
PCL tear				locking			
ACL tear				knee dislocation			
iliotibial band syndrome				knee cap (patella) dislocation			
collateral ligament injury				swelling			
tendonitis				unexplained pain			
bursitis				surgery			
pain around the knee cap (patella)							
other (please specify):							
If any yes answers, please specify date, right/left, etc:							

37. LOWER LEG:

	Yes	No	Now		Yes	No	Now
traumatic fracture				compartment syndrome			
stress fracture				shin splints			
muscle strain				surgery			
other (please specify):							
If any yes answers, please specify date, right/left, etc:							

38. ANKLE:

	Yes	No	Now		Yes	No	Now
traumatic fracture				instability			
stress fracture				bone chip in joint			
sprain				bony dislocation/subluxation			
tendonitis				tendon dislocation/subluxation			
bursitis				surgery			
other (please specify):							
If any yes answers, please specify date, right/left, etc:							

39. FOOT/TOES:

	Yes	No	Now		Yes	No	Now
traumatic fracture				bone spur			
stress fracture				plantar fasciitis			
sprain				tendon dislocation/subluxation			
tendonitis				bony dislocation/subluxation			
				surgery			
other (please specify):							
If any yes answers, please specify date, right/left, etc:							

40. In the past 5 years, have you been treated for a serious injury(s) not mentioned above?

Yes (If yes, please specify below.)

Specify injury(s):	Date

No

**OLD DOMINION UNIVERSITY ATHLETIC TRAINING
DEPARTMENT
ASSUMPTION OF RISK STATEMENT**

I, _____, am aware of and accept the risk of serious injury that may render me disabled or paralyzed as a result of the intercollegiate sport(s) in which I will be participating. I will do my part to reduce the injury risk by keeping myself in the best possible condition and will follow the advice of the team physician(s), athletic trainers, and health clinic personnel concerning the prevention, treatment, rehabilitation and maintenance of any athletic injury.

All of the questions in this form have been answered completely and truthfully to the best of my knowledge.

Signature of Athlete: _____ **Date:** _____