

**OLD DOMINION UNIVERSITY
RETURNING ATHLETE 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.

1. Have you been treated by a doctor for the any of the following conditions during the past 12 months?

	Yes No Now				Yes No Now		
	Yes	No	Now		Yes	No	Now
infectious mononucleosis				bronchitis			
asthma				pneumonia			
tumor, cyst, growth, cancer				hepatitis			
thyroid condition				heart abnormality			
kidney injury/kidney disease				oral/genital herpes			
eating disorder				stomach/intestinal ulcer			
liver/spleen injury				diabetes			
abnormal bleeding				blood in urine			
abnormal clotting problem				frequent urinary tract infections			
Other, please explain:							

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 allergies?

Yes (If yes, to what?): _____

No

4. Do you presently have any of the following skin conditions?

	Yes No	
	Yes	No
rash		
fungal/bacterial infection		
cold sore(s)		

5. In the past 12 months have you experienced any of the following during or following exercise?

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

6. During the recent summer months have you had a head injury?

- Yes
 No

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

7. Do you currently have any problems due to a head injury (i.e. memory loss, headaches, seizures, lack of concentration) or neck injury (pain, numbness, tingling)?

- Yes (If yes, please explain): _____
 No

8. In the recent summer months have you suffered a serious eye injury?

- Yes (If yes, please explain): _____
 No

9. In the recent summer months have you had any vision changes?

- Yes (If yes, please explain): _____
 No

10. In the recent summer months have you had any dental work requiring:

	Yes	No		Yes	No
permanent bridge			full plate		
permanent crown			braces		
removable partial					

11. In the recent summer months have you had surgery to any of the following?

	Yes	No	Now		Yes	No	Now
eye(s)				stomach/bowels			
ear(s)				kidney(s)			
nose				liver			
throat				spleen			
heart				bone			
lung(s)				ligament/joint			

If yes to any answer, please specify date, right/left side, etc: _____

12. During the recent summer months have you had an injury to any of the following?

	Yes	No	Now		Yes	No	Now
shoulder				knee			
elbow				ankle			
wrist				foot			
finger/thumb				neck			
hip				upper back			
quad/hamstring				lower back			
other (please specify):				lower leg			

If yes to any answer, please specify date, right/left side, etc: _____

	<i>Old Dominion University Athletic Training Department Assumption of Risk Statement</i>	
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I, _____, am fully aware of and accept the risk of serious injury that may render me disabled or paralyzed as a result of 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 student health center personnel concerning the prevention, treatment, rehabilitation and maintenance of any athletic injury.

ALL of the above questions have been answered completely and truthfully to the best of my knowledge.

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