

SAINT LOUIS UNIVERSITY SPORTS MEDICINE Student Athlete Questionnaire

Name _____ Sex F M Age _____ Birthdate _____

Banner ID# _____ Sport _____

Local Address _____ Local Phone _____

IN CASE OF EMERGENCY, CONTACT: Name _____

Relationship _____ Phone (h) _____ Phone (w/c) _____

Personal Physician _____ Physician Phone _____

EXPLAIN "YES" ANSWERS IN SPACE ON BACK. CIRCLE QUESTION NUMBERS WHERE YOU DON'T KNOW THE ANSWERS.

- | | | | | | | | | | | | | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--------------------------------|------------------------------------|------------------------------|------------------------------------|-------------------------------|-----------------------------------|--------------------------------|--------------------------------|--------------------------------|-------------------------------|------------------------------------|-------------------------------|-------------------------------|-------------------------------|--|--------------------------------|---------------------------------|--|--|
| <p>1. Have you had a medical illness or injury since your last checkup or sport physical? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. Do you have an ongoing or chronic illness?..... <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. Have you ever been hospitalized overnight? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>4. Have you ever had surgery? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. Are you currently taking any prescription medications or pills or using an inhaler? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. Are you currently taking any nonprescription (over-the-counter) medications or pills? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>7. Are you currently taking, or have you ever taken any supplements to help you gain or lose weight or improve your performance (i.e. Creatine, Calcium, Iron)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>8. Are you currently taking, or have you ever taken any multivitamins to help you gain or lose weight or improve your performance? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>9. Do you have any allergies (i.e. pollen, medicine, food or stinging insects)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>10. Have you ever had a rash or hives develop during or after exercise? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>11. Have you ever passed out during or after exercise? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>12. Have you ever been dizzy during or after exercise? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>13. Have you ever had chest pain during or after exercise?..... <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>14. Do you get tired more quickly than your friends do during exercise? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>15. Have you ever had racing of your heart or skipped heartbeats? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>16. Have you had high blood pressure or high cholesterol? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>17. Have you ever been told that you have a heart murmur?..... <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>18. Has any family member or relative died of heart problems or of sudden death before the age of 50? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>19. Does anyone in your family have Marfan syndrome? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>20. Do you or a family member have sickle cell trait or sickle cell disease?..... <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>21. Have you ever had a severe viral infection (i.e. myocarditis or mononucleosis) within the past 6 months? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>22. Has a physician ever denied or restricted your participation in sports for any problems? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>23. Do you have any current skin problems (i.e. itching, rashes, acne, warts, fungus or blisters)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>24. Have you ever had a head injury or concussion? ... <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>25. Have you ever been knocked out, become unconscious or lost your memory? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>26. Have you ever had a seizure? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>27. Do you have frequent or severe headaches? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>28. Have you ever had numbness or tingling in your arms, hands, legs or feet? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | <p>29. Have you ever had a stinger, burner or pinched nerve? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>30. Have you ever become ill from exercising in the heat? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>31. Do you cough, wheeze or have trouble breathing during or after activity? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>32. Do you have asthma? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>33. Do you have seasonal allergies? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>34. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (i.e. knee brace, foot orthotics, retainer on your teeth, hearing aid)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>35. Have you had any problems with your eyes or vision? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>36. Do you wear glasses, contacts or protective eye wear? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>37. Have you ever had an injury (sprain, ligament tear, tendonitis) that caused you to miss a practice or game? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>38. Have you ever had a stress fracture? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>39. Have you broken or fractured any bones or dislocated any joints? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>40. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><i>If you answered "YES" to questions 37-40, check appropriate box and explain on back.</i></p> <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/> Hip</td> <td><input type="checkbox"/> Shin/Calf</td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Thigh</td> <td><input type="checkbox"/> Ankle</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Upper Arm</td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Knee</td> <td><input type="checkbox"/> Foot</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/> Finger</td> <td></td> <td></td> </tr> </table> <p>41. Do you want to weigh more or less than you do? ... <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>42. Do you lose weight regularly to meet weight requirements for your sport? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>43. Do you feel stressed out? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>44. Are there any groups of food you avoid?..... <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>45. Are you a vegetarian? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>46. Have you ever been diagnosed or are you currently under physician care for Attention Deficit Hyperactivity Disorder (ADHD or ADD)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>47. Are you currently taking any medications to treat ADHD or ADD? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>FEMALES ONLY</p> <p>48. When was your first menstrual period? _____</p> <p>49. When was your most recent menstrual period? _____</p> <p>50. How much time do you usually have from the start of one period to the start of the next? _____</p> <p>51. How many periods have you had in the past year? _____</p> <p>52. What was the longest time between periods in the past year? _____</p> | <input type="checkbox"/> Head | <input type="checkbox"/> Chest | <input type="checkbox"/> Forearm | <input type="checkbox"/> Hip | <input type="checkbox"/> Shin/Calf | <input type="checkbox"/> Neck | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Wrist | <input type="checkbox"/> Thigh | <input type="checkbox"/> Ankle | <input type="checkbox"/> Back | <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Hand | <input type="checkbox"/> Knee | <input type="checkbox"/> Foot | | <input type="checkbox"/> Elbow | <input type="checkbox"/> Finger | | |
| <input type="checkbox"/> Head | <input type="checkbox"/> Chest | <input type="checkbox"/> Forearm | <input type="checkbox"/> Hip | <input type="checkbox"/> Shin/Calf | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Wrist | <input type="checkbox"/> Thigh | <input type="checkbox"/> Ankle | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Back | <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Hand | <input type="checkbox"/> Knee | <input type="checkbox"/> Foot | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> Elbow | <input type="checkbox"/> Finger | | | | | | | | | | | | | | | | | | | |

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and accurate.

Signature of Athlete _____ Date _____

Signature of Parent/Guardian _____ Date _____

FAMILY HISTORY

	Age	State of Health	Occupation	Cause of Death
Father				
Mother				
Brothers/ Sisters				
Husband/ Wife or Children				

Have any of your relatives had?

	Yes	Relationship
Asthma		
Arthritis		
Cancer		
Diabetes		
Epilepsy		
Heart Disease		
Kidney Disease		
Stomach Trouble		
Stroke		
Tuberculosis		

PERSONAL HISTORY

Have you experienced any of the following? Please comment on any positive answers below.

	Yes		Yes		Yes		Yes
Alcohol Abuse		Dizziness		Hay Fever		Pneumonia	
Asthma		Ear Problems		Headache (recurrent)		Rheumatic Fevers	
Back Problems		Hearing Loss		Heart Disease		Rupture/Hernia	
Blood Disorders		Do you require signing?		Hepatitis		Scarlet Fever	
Blood Pressure, High		Epilepsy		HIV Infection		Sexually Transmitted Disease	
Blood Pressure, Low		Eye Disorder, Infection		Jaundice		Substance Abuse	
Chest Pain/Pressure		Sight loss?		Kidney Disorder		Sleep Disturbance	
Chronic Cough		Do you require a reader?		Malaria		Stomach Disorder	
Dental Disorder		Eating Changes (recent)		Mental Illness		Surgery (type/date)	
Depression		Weight Gain		Mononucleosis (Mono)		Throat Problems	
Diabetes		Weight Loss		Mood Swings		Tumor/Cancer/Cyst	
Dysmenorrhea, Cramps		Diet restrictions?		Muscle/Bone Problems		Weakness/Paralysis? Do you need handicapped assistance?	
Excessive Flow		Gall Bladder Disorder		Nasal Problems			
Irregular Flow		Gum Disease		Palpitations			

COMMENT SECTION

Please comment on any positive answers: _____

Medications taken regularly, prescription and nonprescription (list): _____

Allergies to drugs, food, molds, etc. (list): _____

Have you had any illness or injury other than already noted? If so, please list: _____

PARENTAL CONSENT

The law requires, with certain exceptions, that parental permission be obtained for operative and therapeutic procedures on minors. The following consent form must be signed by the parent or legal guardian, so that medical or emergency procedures can be carried out promptly, reducing unnecessary delay and discomfort. I give my permission for such medical procedures as may be deemed necessary for my son/daughter.

Name of Student _____ Date _____

Signature of parent/guardian _____ Relationship to student _____

Phone (h) _____ Phone (w/c) _____