

SAINT LOUIS UNIVERSITY SPORTS MEDICINE

Student Athlete Health Questionnaire

Name _____	Sex <input type="checkbox"/> F <input type="checkbox"/> M	Age _____	Birthdate _____
Social Security # _____ - _____ - _____	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.

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|--|---|------------------------------------|------------------------------------|------------------------------|-------------------------------|--------------------------------|--------------------------------|-------------------------------|----------------------------------|-------------------------------|--------------------------------|--------------------------------|------------------------------------|-----------------------------------|-------------------------------|--------------------------------|--|---------------------------------|-------------------------------|
| <p>1. Have you had a medical illness or injury since your last checkup or sport physical? _____ YES ___ NO</p> <p>2. Do you have an ongoing or chronic illness? _____ YES ___ NO</p> <p>3. Have you ever been hospitalized overnight? _____ YES ___ NO</p> <p>4. Have you ever had surgery? _____ YES ___ NO</p> <p>5. Are you currently taking any prescription or nonprescription (over-the counter) medications or pills or using an inhaler? _____ YES ___ NO</p> <p>6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance (i.e. Creatine or Multivitamins)? _____ YES ___ NO</p> <p>7. Do you have any allergies (i.e. pollen, medicine, food, or stinging insects)? _____ YES ___ NO</p> <p>8. Have you ever had a rash or hives develop during or after exercise? _____ YES ___ NO</p> <p>9. Have you ever passed out during or after exercise? _____ YES ___ NO</p> <p>10. Have you ever been dizzy during or after exercise? _____ YES ___ NO</p> <p>11. Have you ever had chest pain during or after exercise? _____ YES ___ NO</p> <p>12. Do you get tired more quickly than your friends do during exercise? _____ YES ___ NO</p> <p>13. Have you ever had racing of your heart or skipped heartbeats? _____ YES ___ NO</p> <p>14. Have you had high blood pressure or high cholesterol? _____ YES ___ NO</p> <p>15. Have you ever been told that you have a heart murmur? _____ YES ___ NO</p> <p>16. Has any family member or relative died of heart problems or of sudden death before the age of 50? _____ YES ___ NO</p> <p>17. Have you ever had a severe viral infection (i.e. myocarditis or mononucleosis) within the past 6 months? _____ YES ___ NO</p> <p>18. Has a physician ever denied or restricted your participation in sports for any problems? _____ YES ___ NO</p> <p>19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)? _____ YES ___ NO</p> <p>20. Have you ever had a head injury or concussion? _____ YES ___ NO</p> <p>21. Have you ever been knocked out, become unconscious, or lost your memory? _____ YES ___ NO</p> <p>22. Have you ever had a seizure? _____ YES ___ NO</p> <p>23. Do you have frequent or severe headaches? _____ YES ___ NO</p> <p>24. Have you ever had numbness or tingling in your arms, hands, legs or feet? _____ YES ___ NO</p> <p>25. Have you ever had a stinger, burner or pinched nerve? _____ YES ___ NO</p> <p>26. Have you ever become ill from exercising in the heat? _____ YES ___ NO</p> | <p>27. Do you cough, wheeze, or have trouble breathing during or after activity? _____ YES ___ NO</p> <p>28. Do you have asthma? _____ YES ___ NO</p> <p>29. Do you have season allergies? _____ YES ___ NO</p> <p>30. 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)? _____ YES ___ NO</p> <p>31. Have you had any problems with your eyes or vision? _____ YES ___ NO</p> <p>32. Do you wear glasses, contact or protective eyewear? _____ YES ___ NO</p> <p>33. Have you ever had a sprain, strain or swelling after injury? _____ YES ___ NO</p> <p>34. Have you broken or fractured any bones or dislocated any joints? _____ YES ___ NO</p> <p>35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? _____ YES ___ NO</p> <p><i>If you answered yes to questions 33-35, check appropriate box and explain on back.</i></p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Upper Arm</td> <td><input type="checkbox"/> Hip</td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/> Thigh</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/> Knee</td> </tr> <tr> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Shin/calf</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Ankle</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Finger</td> <td><input type="checkbox"/> Foot</td> </tr> </table> <p>36. Do you want to weigh more or less than you do? _____ YES ___ NO</p> <p>37. Do you lose weight regularly to meet weight requirements for your sport? _____ YES ___ NO</p> <p>38. Do you feel stressed out? _____ YES ___ NO</p> <p>39. Are there any groups of food you avoid? _____ YES ___ NO</p> <p>40. Are you a vegetarian? _____ YES ___ NO</p> <p>41. Do you take calcium supplements? _____ YES ___ NO</p> <p>42. Do you take a multivitamin? _____ YES ___ NO</p> <p>43. Do you take an iron supplement? _____ YES ___ NO</p> <p style="text-align: center;">FEMALES ONLY</p> <p>44. When was your first menstrual period? _____</p> <p>45. When was your most recent menstrual period? _____</p> <p>46. How much time do you usually have from the start of one period to the start of the next? _____</p> <p>47. How many periods have you had in the past year? _____</p> <p>48. What was the longest time between periods in the past year? _____</p> | <input type="checkbox"/> Head | <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Hip | <input type="checkbox"/> Neck | <input type="checkbox"/> Elbow | <input type="checkbox"/> Thigh | <input type="checkbox"/> Back | <input type="checkbox"/> Forearm | <input type="checkbox"/> Knee | <input type="checkbox"/> Chest | <input type="checkbox"/> Wrist | <input type="checkbox"/> Shin/calf | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Hand | <input type="checkbox"/> Ankle | | <input type="checkbox"/> Finger | <input type="checkbox"/> Foot |
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| | <input type="checkbox"/> Finger | <input type="checkbox"/> Foot | | | | | | | | | | | | | | | | | |

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/Fainting		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		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 or 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 _____

Signature of parent/guardian _____

Date _____

Relationship to student _____

Telephone _____ Work _____