SPORTS MEDICINE/ATHLETIC TRAINING
MEDICAL HEALTH QUESTIONNAIRE

Instructions: Complete all sections as required. **Press submit when complete. Physician must sign last page!**

Athlete Information:

Athlete Name **Date of Birth** **Height** **Weight** **Gender**

Cell Phone Number **Social Security Number** **Student ID**

Campus Address **Permanent Address**

City **State** **Zip** **City** **State** **Zip**

Parent(s) Information:

Parent/Guardian Name **Permanent Address (If different than Athlete above)**

Home Phone# **Address**

Work Phone#

Cell Phone # **City** **State** **Zip**

Parent/Guardian Name **Permanent Address (If different than Athlete above)**

Home Phone# **Address**

Work Phone#

Cell Phone # **City** **State** **Zip**

Orthopedic History:

Have you ever had any of the following injuries or medical conditions:

1. **Head Injury/Concussion**
    a. **List Dates/Times Missed:**

    b. **Describe Injury:**

    c. **Have you ever been knocked out, hospitalized, became unconscious, or lost your memory due to Head Injury?**

    d. **Were any Diagnostic Tests performed?**

2. **Headaches**
    a. **How often?**

    b. **Where are they located?**

Orthopedic History- Continued:

3. **History of Migraines**
    a. **How often?** **Describe:**

    b. **Where are they located?**

4. **Had headaches for more than 3 months**
    a. **If Yes, please explain:**

5. **Cervical Spine/Neck Injury**
    a. **Date of Injury:**

    b. **Dates and Time Missed:**

    c. **Describe Injury:**

    d. **Diagnostic Tests performed:** **X-Rays** **MRI** **CT Scan** **Other:**

    e. **Were you hospitalized:**

    f. **Describe hospitalization:**

6. **"Burners", "Stingers", or Brachial Plexus Injury?**

    a. **Date of last injury:**

    b. **Number of times injury has occurred?**

    c. **On which side of the body did the injury occur?**

    d. **Describe how the injury occurred:**

    e. **Dates and Time missed:**

    f. **Have you ever had surgery on your neck?**

    g. **Have you ever worn or been advised to wear a neck roll, neck collar or other restrictive device?**

7. **Shoulder/Upper Arm Injury?**

    a. **Date of Injury:**

    b. **On which side of the body did the injury occur?**

c. **Describe how the injury occurred?**

d. **Diagnostic Tests performed: X-Rays MRI Other:**

e. **Have you had past surgeries?**
Explain the type of surgery:

8. **Elbow/Forearm Injury**

a. **Date of Injury:**

b. **On which side of the body did the injury occur?**

c. **Describe injury:**

d. **Diagnostic Tests performed: X-Rays MRI Other:**

e. **Have you had past surgeries?**

f. **Explain the type of surgery:**

9. **Wrist/Hand/Fingers Injury**

a. **Date of Injury:**

b. **On which side of the body did the injury occur?**

c. **Describe Injury:**

d. **Diagnostic Tests performed: X-Rays MRI Other:**

e. **Have you had past surgeries?**

f. **Explain the type of surgery:**

10. Spine/Low Back/Sacrolliac joint injury

a. **Date of Injury:**

b. **On which side of the body did the injury occur?**

c. **Describe Injury:**

d. **Diagnostic Tests performed:** **X-Rays** **MRI** **Other:**

e. **Have you had past surgeries?**

f. **Explain the type of surgery:**

g. **Do you have numbness or pain down one or both legs**

11. Ribs/Thorax/Chest Injury

a. **Date of Injury:**

b. **On which side of the body did the injury occur?**

c. **Describe Injury:**

d. **Diagnostic Tests performed:** **X-Rays** **MRI** **Other:**

e. **Have you had past surgeries?**

f. **Explain the type of surgery:**

12. Hip/Groin Injury

a. **Date of Injury:**

b. **On which side of the body did the injury occur?**

c. **Describe Injury:**

d. **Diagnostic Tests performed:** **X-Rays** **MRI** **Other:**

e. **Have you had past surgeries?**

f. **Explain the type of surgery:**

13. Thigh (Hamstrings and Quadriceps) Injury

a. **Date of Injury:**

b. **On which side of the body did the injury occur?**

c. **Describe Injury:**

d. **Diagnostic Tests performed: X-Rays MRI Other:**

e. **Have you had past surgeries?**

f. **Explain the type of surgery:**

14. Knee Injury (Right/or Left)

a. **Date of Injury:**

b. **On which side of the body did the injury occur?**

c. **Describe Injury:**

d. **Diagnostic Tests performed: X-Rays MRI Other:**

e. **Have you had past surgeries?**

f. **Explain the type of surgery:**

g. **Do you currently wear a knee brace?**

15. Ankle/Lower Leg Injury

a. **Date of Injury:**

b. **On which side of the body did the injury occur?**

c. **Describe Injury:**

d. **Diagnostic Tests performed:** **X-Rays** **MRI** **Other:**

e. **Have you had past surgeries?**

f. **Explain the type of surgery:**

16. Foot/Toe(s) Injury

a. **Date of Injury:**

b. **On which side of the body did the injury occur?**

c. **Describe Injury:**

d. **Diagnostic Tests performed:** **X-Rays** **MRI** **Other:**

e. **Have you had past surgeries?**

f. **Explain the type of surgery:**

<u>Medical Testing:</u>

1. **Have you ever been tested for HIV/AIDS that you are aware of?**
2. **Have you ever contracted any type of Hepatitis?** **Type:** **A** **B** **C**
3. **Have you ever received Hepatitis B vaccination series (all three shots)?**
4. **Have you had a positive test for MRSA for skin infection?**

Heat Related Problems:

1. **Have you ever experienced (Check all that apply):**
   Heat Cramps Heat Exhaustion Heat Stroke

2. **Have you ever received intravenous fluids for a heat related problem?**

3. **Have you ever been hospitalized for a heat related problem?**

Allergies:

1. **Have you been diagnosed with food or drug allergies?**
   a. **List all known allergies:**

2. **Do you take allergy medications?**

3. **Do you have any allergic reaction to any insect stings?**

   a. **Do you have an epi-pen?**

Diabetic History:

1. **Have you been diagnosed with Diabetes?**
   What type of Diabetes? Type I Type II

   a. **List Medication Dose/Schedule:**

   b. **Do you use an insulin pump?**

   c. **Describe your schedule of testing blood sugars:**

   d. **List any precautions that you take or any additional information:**

   e. **Most recent HgbA1C level % Date**

Asthma:

1. **Do you have asthma or Exercise Induced Asthma?**
   a. **Describe:**

2. **Do you take medications for your Asthma?**

3. **Are you currently under the care of a physician for your asthma problem?**

Cardiovascular:

1. **Have you ever had chest pain and/or shortness of breath during or after exercise/practice?**
2. **Have you ever felt dizzy, light-headed and/or passed out during or after exercise/practice?**
3. **Have you ever had the feeling of your heart racing or skipping a beat during or after exercise?**
4. **Have you ever been told you have a heart murmur?**
5. **Has any family member died of heart problems or sudden death before the age of 35?**
    a. **If Yes, explain:**
6. **Has any family member been treated for heart related problems?**
    a. **If Yes, explain:**
7. **Has a physician ever restricted your participation in sports due to a heart condition?**
8. **Have you ever had an electrocardiogram (EKG) or stress test of your heart?**
    a. **What were the results?**
9. **Do you have high blood pressure?**
10. **Do either of your parents have high blood pressure and take medication?**

Body Composition/Nutrition:

1. **Have you had an undesired weight change (loss or gain) greater than 10 pounds in the last year?**
2. **Do you regularly lose weight to participate in your sport?**
3. **Do you want to weigh less or more than you do presently?**
4. **Have you ever felt forced to limit your food intake?**
5. **Do you use performance enhancers? (e.g. protein powder, creatinine, energy drink, caffeine, others)**
    a. **If Yes, please specify:**
6. **Do you have now or had in the past anorexia or bulimia?**
7. **Do you follow a special diet?**
    b. **If Yes, what kind?**

Medications/Nutritional Supplements:

1. **List any medications you are currently taking:**

2. **List any nutritional supplements you are currently taking:**

Immunizations:

Please check all up to date immunizations: **Tetanus** **MMR**
Chicken Pox **HBV**

General:

1. **Do you have any skin problems?**
    a. **If Yes, what kind?**

2. **Are you currently under the care of a physician for any medical condition?**
    a. **If Yes, please explain:**

3. **Do you have a chronic illness?**
    a. **If Yes, please explain:**
4. **I am being treated or have been treated for a seizure disorder previously**
5. **I often have trouble sleeping**
6. **I wish I had more energy most days of the week**
7. **I think about things over and over**
8. **I feel anxious and nervous much of the time**
9. **I often feel sad or depressed**
10. **I struggle with being confident**
11. **I do not feel hopeful about the future**
12. **I have a hard time managing my emotions (frustration, anger, impatience).**
13. **I have feelings of hurting myself or others.**
14. **Have you ever been hospitalized overnight?**
    a. **If Yes, please explain:**

15. **Have you ever been under the care of a psychiatrist or psychologist?**
    a. **If Yes, please explain:**

Female Athletes Only:

1. **When was your first menstrual period?**

2. **How many menstrual periods have you had in the last 12 months?**

3. **When was your most recent menstrual period?**

4. **Do you have painful or heavy menstrual periods?**

5. **Do you take medication during your menstrual periods?**
    a. **If Yes, please explain:**

6. **Do you take birth control pills?**
    a. **If Yes, list medication:**

7. **Have you ever had any problems with your breasts?**

8. **Have you had a pelvic exam within the last 12 months?**

9. **Are you currently pregnant?**

Do you know or do you believe there is any health reason why you should not participate in the UW-Whitewater Intercollegiate Athletic Program?

Have you ever been advised by a medical doctor not to participate in the sport in which you are planning to participate in?

Student Athlete Acknowledgement/Signatures

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

Student/Athlete Signature **Date**

Parent/Guardian Signature (if under age 18) **Date**

Freshman and Transfer Student Athletes MUST have this form signed by the Doctor performing physical.

Physician Signatures

Physician Signature **Date**

Physician Name (Please Print)