Eastern Kentucky Sports Medicine
Medical History Questionnaire

Date:______/_____/_____
(Month) (Day) (Year)

Athlete's Name:____ Section of Band:_______________________
(Last) (First) (Middle) (Nickname)

Social Security No:_________/____/________ Date of Birth:_____/______/______ _______/______/_________
(Month) (Day) (Year) (Age) (Sex) (Race)

Student No:_____________________ Classification: Fr. So. Jr. Sr. Other_________
(if different from SSN) (Circle one)

Local Address, Dormitory, etc.____

Local Phone:(_____)______________ Cell Phone:(____)______________ E-mail Address:_____________________________

*****NOTE: <u>ALL</u> information will be kept <u>CONFIDENTIAL</u>*****

I. Person to Notify in Case of an Emergency

Name:____ Relationship:__________________________
Address:____
(City) (State) (ZIP)
Home Phone:(____)__________________ Cell Phone:(_____)___________________
Business Phone:(____)________________ E-mail:______________________________

II. Parent/Guardian 1

Name:______________________________________

Address:____________________________________
____
(City) (State) (ZIP)

E-mail:_____________________________________

Home Phone:(______)_______________________

Cell Phone:(______)_________________________

Business Phone:(_____)______________________

III. Parent/Guardian 2

Name:______________________________________

Address:____________________________________
____
(City) (State) (ZIP)

E-mail:_____________________________________

Home Phone:(______)_______________________

Cell Phone:(______)_________________________

Business Phone:(_____)______________________

IV. Physician

Name of Family Physician(s):______________________________________ Business Phone:(____)__________
Address:____
(City) (State) (ZIP)

V. Previous Universities

Colleges previously attended (if applicable):______________________________ Business Phone:(____)__________
Address:____
(City) (State) (ZIP)
Band Director's Name:__________________________ Athletic Trainer's Name:__________________________

VI. Family Medical History: Is there a history of any of the following for any blood relative?

Cancer	YES	NO	Skin Cancer	YES	NO	Alcoholism/Drug Abuse	YES	NO
Diabetes	YES	NO	Epilepsy/Seizures	YES	NO	Sudden death before age 50	YES	NO
Heart Trouble	YES	NO	Mental Illness	YES	NO	Sickle Cell Trait/ Disease	YES	NO
High Blood Pressure	YES	NO	Depression	YES	NO	Bleeding Disorder/ Blood Disease	YES	NO
Obesity	YES	NO	Suicide	YES	NO	Stroke	YES	NO

VII. Medications: Please list all medications you are currently taking.

VIII. General Medical Allergies: Please indicate whether you are allergic to any of the following items.

Aspirin	YES	NO	Penicillin	YES	NO	Tetanus Antitoxin or Serums	YES	NO	Bee Stings	YES	NO
Codeine	YES	NO	Erythromycin	YES	NO	Novocain or Other Anesthetics	YES	NO	Fire Ant Bites	YES	NO
Sulfa Drugs	YES	NO	Ibuprofen	YES	NO	Hay Fever-Dust/Pollen/ Mold/Grass	YES	NO	Wasp Stings	YES	NO
Iodine	YES	NO	Acetaminophen	YES	NO	Oral Anti-Inflammatory	YES	NO	Latex	YES	NO

1. Are you allergic to any other drugs, medications, foods, plants, insect bites/stings, etc. not listed above? If yes, please list those allergies here:	YES	NO
2. Have you ever had any reaction to serum drugs? If yes, please list the drugs and related details here:	YES	NO

IX. Gynecological History: ***<u>ONLY</u> females answer this section***

Check YES or NO for the following and if the answer is YES, write in the age at which the condition occurred.

	YES	NO	AGE		YES	NO	AGE
Scanty Flow				Menstrual Cramps			
Excessive Flow				Irregular Periods			
Vaginal Discharge				Lumps in Breasts			
Absence of Menstruation				Genital Itching			
Painful Menstruation				Genital Burning			
Ovarian Cysts				Endometriosis			
Nipple Discharge				Decreased Bone Density			
	NUMBER	**DATE**	**AGE**	Other (please specify):			
Pregnancies							
Births							
Abnormal Pap Smears							

Last Period:	Last Pap Smear:	Average Length of Cycle:	Average Period Duration:	Age Periods Began:
Are you currently using any form of birth control?	YES	NO	If yes, please specify which type (pill, IUD, implant, etc.):	

X. Medical Illness History: Have you ever had or do you now have any of the conditions below? If so, check YES and write in the age at which the condition occurred. If not, check NO.

CHECK EACH ITEM	YES	NO	AGE	CHECK EACH ITEM	YES	NO	AGE	CHECK EACH ITEM	YES	NO	AGE
Car, Air, or Motion Sickness				Venereal Disease (STD/STI)				Frequent Indigestion			
Ear, Nose, Throat Trouble				Contact with AIDS or HIV				Cancer			
Asthma				Mononucleosis				Tumor/Growth/Cyst			
Vocal Cord Dysfunction				Chronic Frequent Colds				Skin Trouble/Cancer			
Bronchitis				Kidney Trouble				Rheumatism			
Chronic Cough				Kidney Stones				Increased Heart Rate			
Tuberculosis				Bloody Urine				Pain/Pressure in Chest			
Fever Blisters				Sugar in Urine				Shortness of Breath			
Mumps				Albumin in Urine				Heartburn			
3-Day Measles				Painful Urination				Psychiatric Problems			
Rheumatic Fever				Frequent Urination				Fear of High Places			
Scarlet Fever				Rectal Bleeding/Itching				Excessive Worry			
Typhoid Fever				Hemorrhoids				Depression			
Chicken Pox				Gout				Nervous Trouble			
Small Pox				Goiter/Thyroid Disease				Insomnia			
Shingles				Peptic Ulcer				Neuritis			
Diphtheria				Gall Bladder Trouble				Convulsions/Seizures			
Polio				Gallstones				Dizziness			
Malaria				Appendicitis				Paralysis			
Obesity				Liver Trouble				Amnesia			
Urinary Tract Infection				Athletes Foot				Migraine Headaches			
Ringworm				Jock Itch				Frequent Headaches			
Lyme Disease				Nausea/Vomiting				Jaundice			
Herpes Virus				Intestinal Trouble				Whooping Cough			
Hepatitis B (HBV)				Stomach Trouble				Anemia(s)			

XI. General Medical Information: Circle YES or NO and specify if needed.

1. Do you have a form of heart disease? If yes, please list any medications taken for this condition:	**YES**	**NO**
2. Do you have a heart disorder? If yes, please list any medications taken for this condition:	**YES**	**NO**

3. Have you ever had one of the following tests performed for a heart condition?

Electrocardiogram (EKG)	**YES**	**NO**
Echocardiogram	**YES**	**NO**
Treadmill Stress Test	**YES**	**NO**

4. During the past year (twelve months) have you had any type of problem with tolerance to exercise? If yes, please give a brief explanation.	**YES**	**NO**

5. Do you have hypertension (high blood pressure)?	**YES**	**NO**
6. Do you have hypotension (low blood pressure)?	**YES**	**NO**
7. Have you ever passed out or had fainting spells?	**YES**	**NO**
8. Did this occur with exertional activities?	**YES**	**NO**

9. Are you a diabetic or have you ever been treated for diabetes? If yes, please list the age at which your diabetes began as well as all medications you take for this condition:	**YES**	**NO**
10. Do you have hypoglycemia (low blood sugar)?	**YES**	**NO**

11. Do you have a vision defect in either one or both eyes and if yes, please specify below:	**YES**	**NO**

12. Do you have a hearing defect? If yes, please specify below and list any hearing aids worn:	**YES**	**NO**

22. Do you wear any dental appliances?	**YES**	**NO**

29. In the past 12 months, have you been treated for:

Mononucleosis?	**YES**	**NO**
Pneumonia?	**YES**	**NO**
Infectious Virus?	**YES**	**NO**

30. Have you ever had trouble with dehydration (excess loss of salt and water)?	**YES**	**NO**
31. Have you ever had trouble with heat intolerance?	**YES**	**NO**
32. Do you have Sickle-Cell Anemia or Trait? Which one?	**YES**	**NO**
Any family member with Sickle-Cell Anemia? Who?	**YES**	**NO**
Any other blood or Anemia problems? Please specify:	**YES**	**NO**

33. Have you ever been diagnosed with Vocal Cord Dysfunction? If yes, how are you managing it?	**YES**	**NO**

34. Have you ever suffered from or been diagnosed with Exercise Induced Asthma (EIA)? If yes, what medications(s) are you taking to control EIA?	**YES**	**NO**

37. Have you ever had surgery to repair or remove any organ? If yes, please list the organ(s) and details regarding the repair and/or removal including the dates and treating physicians for each:	**YES**	**NO**
39. Are you an epileptic or have you ever had an epileptic seizure? If yes, please list any and all medications you take for this condition:	**YES**	**NO**
42. Have you had either a gain or loss of greater than 10 pounds in the past 12 months?	**YES**	**NO**

XII. Eating Disorders

Have you ever had a problem with food bingeing? If yes, when?	**YES**	**NO**
Has it ever been suggested or have you ever been diagnosed as being anorexic? If yes, when?	**YES**	**NO**
Have you ever been diagnosed as bulimic or having bulimia? If yes, when?	**YES**	**NO**
Do you sometimes or often induce vomiting after eating?	**YES**	**NO**
Have you taken or do you take laxatives to prevent being overweight?	**YES**	**NO**

XIII. Nutrition, Drugs, Food Supplements, and Miscellaneous Agents:

Check the appropriate space according to your use of the following products

	Never	**Rarely**	**Occasionally**	**Frequently**
Stimulants (Benzedrine, Amphetamines, etc.)				
Chewing Tobacco, Snuff, or Smokeless Tobacco				
Cigarettes, Cigars, Pipe, or Vape				
Vitamins or Other Suppliments				
Sleeping Pills				
Diet Pills				
Alcoholic Beverages				
Androstenedione				
Amino Acids (BCAAs, etc.)				
Creatine Phosphate				
Antihistamines				
Ephedrine				
Any other diet, nutritional or performance enhancing drug/hormone				
Any other substances not listed				

XIV. Attention Deficit Hyperactivity Disorder (ADHD)

Have you ever been diagnosed with ADHD? If so, by whom and did they do any tests?	**YES**	**NO**
Are you taking any medications for your ADHD? What medication?__________________________________ Please provide a prescription from your physician at your physical examination. ***<u>**We will also need any and all documentation from your physician who prescribed this medication and why it was prescribed**</u>***	**YES**	**NO**

XV. Non-Athletic Surgery: If you have ever had any non-athletic surgeries, list them below:

Dates	Surgical Procedures	Physicians	Complications (if applicable)

<u>**PLEASE OBTAIN AN OPERATIVE REPORT FOR ANY SURGERIES DUE TO INJURY TO EXTREMITIES FROM YOUR SURGEON AND RETURN WITH THIS FORM TO HELP WITH OUR PHYSICAL EXAMINATION**</u>

XVI. Orthopedic Medical History

Fractures

Have you ever broken (fractured) a bone? If yes, please fill in the appropriate boxes below:				**YES**	**NO**
BODY PART	**DATES**	**BODY PART**	**RIGHT**	**LEFT**	**DATES**
Skull		Collar Bone			
Nose		Upper Arm			
Face		Forearm			
Jaw		Wrist			
Neck		Hand			
Spine		Thigh			
Pelvis		Lower Leg			
Ribs		Foot			
Fingers	R___:1___, 2___, 3___, 4___, 5___		L___:1___, 2___, 3___, 4___, 5___		
Toes	R___:1___, 2___, 3___, 4___, 5___		L___:1___, 2___, 3___, 4___, 5___		

Dislocations

Have you ever dislocated a joint? If yes, please fill out the appropriate boxes on the chart below:								**YES**	**NO**
BODY PART	**RIGHT**	**LEFT**	**NUMBER OF TIMES**	**DATES**	**BODY PART**	**RIGHT**	**LEFT**	**NUMBER OF TIMES**	**DATES**
Shoulder					Elbow				
A-C Joint					Wrist				
Knee Cap					Hip				
Knee					Neck				
Ankle									
Fingers	R___:1___, 2___, 3___, 4___, 5___				L___:1___, 2___, 3___, 4___, 5___				
Toes	R___:1___, 2___, 3___, 4___, 5___				L___:1___, 2___, 3___, 4___, 5___				

Neck

Question		
Have you ever sustained a serious neck/cervical injury?	**YES**	**NO**
Did you have numbness, burning, or sharp pain in your arms or legs?	**YES**	**NO**
Have you ever had an injury producing weakness or numbness or burning of your arms or legs or both?	**YES**	**NO**
Were you ever transported by ambulance for a neck injury?	**YES**	**NO**
If yes, did you have neck or spinal X-rays taken?	**YES**	**NO**
Have you ever had neck surgery? If yes, describe surgery type, date, physician, and location of hospital below:	**YES**	**NO**
Have you ever had a burner or stinger (stretched or pinched nerve)?	**YES**	**NO**
Have you ever had Thoracic Outlet Syndrome (TOS)? When?	**YES**	**NO**
Do you currently have any weakness due to a neck or spinal injury? If yes, give the location(s) of the weakness:	**YES**	**NO**

Spine

Question		
Have you ever injured your back? How many times? Please provide details (dates, treatment, rehabilitation):	**YES**	**NO**

Were you ever diagnosed with a spinal defect of any type? Provide details of defect:	**YES**	**NO**
Have you ever had back surgery? Describe surgery type, date, physician, and location of hospital below:	**YES**	**NO**
Were you placed on a rehabilitation program?	**YES**	**NO**
Do you wear any type of preventative/protective brace?	**YES**	**NO**

Head

Have you ever sustained a concussion (either suspected or diagnosed)? When?	**YES**	**NO**
Do you remember all of your concussions?	**YES**	**NO**
Did you have any memory problems?	**YES**	**NO**
How many concussions have you had?		
What was the severity of your concussion?		
How long were you restricted from playing?		
Were you ever hospitalized for a concussion? How many?	**YES**	**NO**
Have you ever been knocked unconscious? Please list the number of times and if you were also hospitalized because of it.	**YES**	**NO**
Has a head injury or concussion affected your life outside of band (examples: class, social life, sleep, concentration, light/sound irritation)?	**YES**	**NO**
How long did your symptoms last?		
Have you ever had a skull fracture?	**YES**	**NO**
Have you ever had double vision because of a head injury?	**YES**	**NO**
Have you ever had blurred vision because of a head injury?	**YES**	**NO**

XVII. Other

If you have any additional conditions, problems, or comments that have not been addressed thoroughly in the above questionnaire, please use the space below to inform us so that we may be able to better serve you with our best medical care.

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All statements and answers in the above medical history questionnaire are true and complete to the best of my knowledge. I have no abnormality, limitation, or restriction not mentioned in this record. I understand that this information is to help determine my fitness to participate, and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur.

Date__________________ Printed Name____
(First) (Middle) (Last)

Date__________________ Signature____

Date__________________ Signature of Parent/Guardian____
(Not required if 18 years or older)