University of New England Sports Medicine Department

Student-Athlete Health History Questionnaire Form

The information contained in this medical history form will only be used the Sports Medicine Department of the University of New England for purposes of determining if you pose a health threat/risk to yourself on the athletic field. This information will remain **CONFIDENTIAL** at all times.

Please print clearly in **BLUE OR BLACK INK ONLY**

Name_____ Date _____ Class (circle one) Fr. So. Jr. Sr. Date of Birth_____

Social Security #_____ Height (ft/in)_____ Weight (lbs)_____ ☐Right Handed ☐Left Handed

Sport(s)_____ Position(s)_____

SCHOOL ADDRESS

_____
STREET

_____
CITY STATE ZIP CODE

_____
PHONE 1 PHONE 2 (CELLULAR)

HOME ADDRESS

Father's Name_____
Permanent Address (circle one): yes no

Address:

_____
STREET

_____
CITY STATE ZIP CODE

_____
HOME PHONE WORK PHONE

Mother's Home_____
Permanent Address (circle one): yes no

Address:

_____
STREET

_____
CITY STATE ZIP CODE

_____
HOME PHONE WORK PHONE

HEALTH INSURANCE INFORMATION

Insurance Company_____ Phone #_____

Policy#_____ Group#_____

Name on Policy_____

Type of Insurance ___PPO ___HMO ___Indemnity ___Other_____

Primary Care Physician_____ Phone #_____

Part 1. Please Answer ALL questions and for YES answers refer to corresponding page listed to explain.

	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or non-prescription (over the counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have (check all that apply) ☐ High blood pressure ☐ Heart Murmur ☐ High Cholesterol ☐ Heart Infection		
10. Has a doctor ever ordered a test for your heart? (ECG, electrocardiogram, etc.) ***If you answered yes for any questions 3-10 go to page 6***	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis, that caused you to miss a practice or game?	☐	☐
18. Have you had any broken bones or fractured bones, or dislocated joints?	☐	☐
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	☐	☐
20. Have you ever had a stress fracture?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device? ***If you answered yes to any of the questions 18-22 please got o page 3***	☐	☐
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐

	YES	NO
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you had a herpes skin infection?	☐	☐
31. Have you ever had a head injury or concussion? ***If yes go to page 3***.	☐	☐
32. Have you been hit in the head and been confused or lost your memory? ***If yes go to pg3***	☐	☐
33. Have you ever had a seizure?	☐	☐
34. Do you have headaches with exercise?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps, or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with you eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
FEMALES ONLY		
47. Have you ever had a menstrual period?	☐	☐
48. How old were you when you had your first menstrual period?	☐	☐
49. How many periods have you had in the last year?	☐	☐

If you answered yes to questions 31 and/or 32 please explain here.

Please Describe_____

Lists Dates/Time Missed_____

Were any Diagnostic Tests Performed? ☐ Yes ☐ No (check all that apply)

☐ MRI ☐ CT-Scan ☐ Neurophysiological Testing ☐ Other_____

Do you Suffer From Headaches? ☐ Yes ☐ No

When? ☐ Every Day ☐ 1-2 Times/Week ☐ 1-2 Times/Month

Where Are Your Headaches Located? ☐ Left Side of Head ☐ Right Side of Head

☐ Front of Head ☐ Back of Head

☐ All Over Head

Have you had headaches For More than 3 Months? ☐Yes ☐ No Please explain_____

Do You Have a History of Migraine Headaches? ☐Yes ☐No

How often_____ Please Describe_____

Medications Taken for Migraines_____

If you answered yes to question 21 please explain here.

Please Describe_____

Lists Dates/Time Missed_____

Were any Diagnostic Tests Performed? ☐ Yes ☐ No (check all that apply)

☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ X-Ray ☐ Other_____

Have you ever been hospitalized for a Cervical Spine/Neck Injury? ☐ Yes ☐ No

When_____ Where_____

Please Describe_____

Have you ever had "Burners", "Stingers", or any Brachial Plexus Injury? ☐ Yes ☐ No

How many? _____ Dates/Time Missed_____

Have you ever had surgery or any kind on your cervical spine/neck? ☐ Yes ☐ No

When_____ Surgeon_____

Please Describe_____

If you answered yes to any of questions 18-21 and 22 please explain here.

Shoulder/Upper Arm

History of Shoulder / Upper Arm Injury? ☐ Yes ☐ No List Dates/Time Missed_____

Please Describe_____

Were Any Diagnostic Tests Performed? ☐ Yes ☐ No (check all that apply)

☐ X-Rays ☐Bone Scan ☐MRI ☐CT-Scan ☐ Other_____

Have You Ever Been Hospitalized For A Shoulder / Upper Arm Injury? ☐ Yes ☐ No

When? _____ Where? _____

Please Describe_____

Have You Ever Had Surgery of Any Kind on Your Shoulder / Upper Arm? ☐ Yes ☐ No

When? _____Surgeon? _____

Please Describe_____

Have You Ever Experienced Numbness and/or Tingling in Your Arms/Fingers? ☐ Yes ☐ No

Date(s)?_____ Please Describe_____

Elbow/Forearm

History of Elbow / Forearm Injury? □ Yes □ No List Dates/Time Missed_____

Please Describe_____

Were Any Diagnostic Tests Performed? □ Yes □ No (check all that apply)

□X-Rays □Bone Scan □MRI □CT-Scan □ Other_____

Have You Ever Been Hospitalized For An Elbow / Forearm Injury? □ Yes □ No

When? _____ Where?_____

Please Describe_____

Have You Ever Had Surgery of Any Kind on Your Elbow / Forearm? □ Yes □ No
When? _____Surgeon?_____

Please Describe_____

Wrist, Hand, & Fingers

History of Wrist, Hand, and/or Finger Injury? □ Yes □ No List Dates/Time Missed_____

Please Describe_____

Were Any Diagnostic Tests Performed? □ Yes □ No (check all that apply)
□ X-Rays □ Bone Scan □ MRI □ CT-Scan □ Other_____

Have You Ever Been Hospitalized For A Wrist, Hand, and/or Finger Injury? □ Yes □ No
When?_____ Where?_____ Please Describe_____

Have You Ever Had Surgery of Any Kind on Your Wrist, Hand, and/or Finger(s)? □ Yes □ No

When?_____ Surgeon?_____

Please Describe_____

Spine / Low Back / Sacroiliac Joint

History of Spine / Low Back / Sacroiliac Joint Injury? □ Yes □ No List Dates/Time Missed_____

Please Describe_____

Were Any Diagnostic Tests Performed? □ Yes □ No (check all that apply)
□ X-Rays □ Bone Scan □ MRI □ CT-Scan □ Other_____

Have You Ever Been Hospitalized For A Spine / Low Back / Sacroiliac Joint Injury? □ Yes □ No

When? _____ Where? _____

Please Describe_____

Have You Ever Had Surgery of Any Kind on Your Spine / Low Back / Sacroiliac Joint? □ Yes □ No

When? _____Surgeon?_____

Please Describe_____

Have You Ever Had Numbness/Tingling Down One (1) or Both Legs? □ Yes □ No
Date(s)/Time Missed?_____ Please Describe?_____

Ribs / Thorax / Chest

History of Rib / Thorax / Chest Injury? □ Yes □ No List Dates/Time Missed_____

Please Describe_____

Were Any Diagnostic Tests Performed? (check all that apply) □ Yes □ No
□X-Rays □ Bone Scan □MRI □CT-Scan □Other_____

Have You Ever Had Surgery For A Rib / Thorax / Chest Injury? □ Yes □ No
When? _____ Where? _____

Please Describe_____

Hip / Groin

History of Hip / Groin Injury? □ Yes □ No List Dates/Time Missed_____

Please Describe_____

Were Any Diagnostic Tests Performed? (check all that apply) □ Yes □ No
□X-Rays □ Bone Scan □MRI □CT-Scan □Other_____

Have You Ever Had Surgery For A Hip/Groin Injury? □ Yes □ No
When? _____ Where? _____

Please Describe_____

Thigh *(including Quadriceps & Hamstrings)*

History of Thigh Injury? □ Yes □ No List Dates/Time Missed_____

Please Describe_____

Were Any Diagnostic Tests Performed? □ Yes □ No (check all that apply)
□ X-Rays □ Bone Scan □ MRI □ CT-Scan □ Other_____

Have You Ever Been Hospitalized For A Thigh Injury? □ Yes □ No
When?_____ Where?_____ Please Describe_____

Have You Ever Had Surgery of Any Kind on Your Thigh(s)? □ Yes □ No

When?_____ Surgeon?_____

Please Describe_____

Knee

History of Knee Injury? □ Yes □ No List Dates/Time Missed_____

Please Describe_____

Were Any Diagnostic Tests Performed? □ Yes □ No (check all that apply)
□ X-Rays □ Bone Scan □ MRI □ CT-Scan □ Other_____

Have You Ever Been Hospitalized For A Knee Injury? □ Yes □ No
When?_____ Where?_____ Please Describe_____

Have You Ever Had Surgery of Any Kind on Your Knee(s)? □ Yes □ No

When?_____ Surgeon?_____

Please Describe_____

Have You Ever/Do You Presently Wear A Knee Brace? □ Yes □ No

Which Knee?_____ Brand / Model of Brace?_____

Reason for Wearing ?_____

Ankle / Lower Leg

History of Ankle Injury? □ Yes □ No List Dates/Time Missed_____

Please Describe_____

Were Any Diagnostic Tests Performed? □ Yes □ No (check all that apply)
□ X-Rays □ Bone Scan □ MRI □ CT-Scan □ Other_____

Have You Ever Been Hospitalized For An Ankle Injury? □ Yes □ No
When?_____ Where?_____ Please Describe_____

Have You Ever Had Surgery of Any Kind on Your Knee(s)? □ Yes □ No

When?_____ Surgeon?_____

Please Describe_____

Do You Presently Tape Your Ankle(s) Use Ankle Brace(s)? □ Yes □ No

Which Ankle?_____ Brand / Model of Brace?_____

Reason for Wearing ?_____

Foot / Toes

History of Foot / Toe Injury? □ Yes □ No List Dates/Time Missed_____

Please Describe_____

Were Any Diagnostic Tests Performed? (check all that apply) □ Yes □ No
□X-Rays □ Bone Scan □MRI □CT-Scan □Other_____

Have You Ever Had Surgery For A Foot / Toe Injury? □ Yes □ No
When? _____ Surgeon? _____

Please Describe_____

If you answered yes to question 3 please explain here.

Please list ALL prescription and over the counter medications that you are taking or have taking in the past and for what purpose:

Medication	Purpose	Dosage	Date(s)

If you answered yes to question 4 please explain here.

Have You Ever Been Diagnosed With Any Allergies? □ Yes □ No

Please Describe_____

Are You Presently Taking/Have You Previously Taken Any Allergy Medications? □ Yes □ No

Please Describe_____

Are you allergic to and/or ever had an unfavorable / allergic reaction to any medications? □ Yes □ No

Please Describe_____

Are you allergic to and/or ever had an unfavorable / allergic reaction to any food items? □ Yes □ No

Please Describe_____

Are you allergic to and/or ever had an unfavorable / allergic reaction to bee stings, insect bites, etc.? □ Yes □ No

Please Describe_____

If you answered yes to any of questions 5-10 please explain here.

Have you ever had chest pain and/or shortness of breath during or after exercise / practice?

Please Describe_____

Have you ever felt dizzy, lightheaded, and/or passed out during or after exercise / practice?

Please Describe_____

Have you ever had the feeling of your heart racing or skipping beats during or after exercise / practice?

Please Describe_____

Do you get tired more quickly than your teammates / friends do during exercise / practice?

Please Describe_____

Have you ever been told that you have a heart murmur?

Please Describe_____

Has any family member or relative died or heart problems and/or of sudden death before age 35?

Please Describe_____

Has a physician ever denied or restricted your participation in sports due to any heart problems?

Please Describe_____

Have you ever had an electrocardiogram (EKG) of your heart?

Dates / Please Describe_____

Have you ever been told that you have / had high blood pressure?

Please Describe_____

Have you even been told that you have / had high blood cholesterol?

Please Describe_____

I, the undersigned, hereby acknowledge, affirm, and represent that all statements on pages one (1) through six (6) are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I fully understand that the University of New England, its agents, servants, trustees, and employees disclaim liability, and will not be held liable for any injuries and/or illnesses not noted.

Student-Athlete Signature _____ Date _____

Student-Athlete Print Name _____

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

Parent/Guardian Print Name _____

Witness _____ Date _____

Please describe below any further injury information, which is knowledgeable to you and not required on this form.

Reviewed By:

Reviewers's Signature _____ Date _____

Reviewer's Print Name _____

Please return all forms by fax or mail to:
University of New England
Attn: Angela Potter-Campus Center
11 Hills Beach Road
Biddeford, ME 04005
Fax: (207) 602-5912