Allegany College of Maryland Sports Medicine Department
Student-Athlete Health History Questionnaire Form

The information contained in this medical history form will only be used by the Sports Medicine Department of Allegany College of Maryland 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.

Student-Athlete Name: ______________________________ Today's Date: ______________

Date of Birth: ______________________________ Sport(s): ______________________________

I. Cardiovascular Risk Factors:

- Have you ever had chest pain and/or shortness of breath during or after exercise / practice? ___ YES ___ NO
- Have you ever felt dizzy, lightheaded, and/or passed out during or after exercise / practice? ___ YES ___ NO
- Have you ever had the feeling of your heart racing or skipping beats during or after exercise / practice? ___ YES ___ NO
- Do you get tired more quickly than your teammates / friends do during exercise / practice? ___ YES ___ NO
- Have you ever been told that you have a heart murmur? ___ YES ___ NO
- Has any family member or relative died or heart problems and/or of sudden death before age 50? ___ YES ___ NO
- Has a physician ever denied or restricted your participation in sports due to any heart / cardiovascular problems? ___ YES ___ NO
- Have you ever had an electrocardiogram (EKG) and/or echocardiogram (ECHO) of your heart? ___ YES ___ NO
- Does anyone in your family have a history of high blood pressure? ___ YES ___ NO
- Have you ever been told that you have / had high blood pressure? ___ YES ___ NO
- Does anyone in your family have a history of high blood cholesterol? ___ YES ___ NO
- Have you even been told that you have / had high blood cholesterol? ___ YES ___ NO

Please describe any **YES** answers: ______________________________

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XIII. Ribs / Thorax / Chest:

- Have You Ever Suffered An Injury To Your Rib / Thorax / Chest? ___ YES ___ NO
- Were Any Diagnostic Tests Performed? (check all that apply) ___ X-Rays ___ MRI ___ CT-Scan ___ Bone Scan
- Have You Ever Had Surgery For A Rib / Thorax / Chest Injury? ___ YES ___ NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Ribs, Thorax, and/or Chest Injury? ___ YES ___ NO
- Please describe any **YES** answers: ______________________________

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XIX. Abdomen:

- Have You Ever Been Diagnosed With A Problem With Your Stomach, Abdomen, Intestines, or Rectum? ___ YES ___ NO
- Have You Ever Suffered An Injury To Your Abdomen? ___ YES ___ NO
- Were Any Diagnostic Tests Performed? (check all that apply) ___ X-Rays ___ MRI ___ CT-Scan ___ Bone Scan
- Have You Ever Had Surgery For An Abdomen Injury? ___ YES ___ NO
- Do You Routinely Suffer From Severe Or Recurrent Abdominal Pain? ___ YES ___ NO
- Do you Routinely Suffer From Chronic or Recurrent Diarrhea? ___ YES ___ NO

- Do You Have Only One Of Two Paired, Functioning Organs (e.g. kidney, testicles, ovary, etc.)? ▭ YES ▭ NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Abdomen Injury? ▭ YES ▭ NO
- Please describe any **YES** answers: ______________________________

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IV. Head Injuries / Concussion:

- Have You Ever Suffered a Head Injury / Concussion (no matter how minor)? ▭ YES ▭ NO

  If YES: How many diagnosed concussions have you had? (Please Circle): 1 2 3 4 +
- When was your most recent, please describe length/recovery time: ______________________________
- Have you ever been hospitalized for a Head Injury / Concussion? ▭ YES ▭ NO
- Please Describe ______________________________
- Were Any Diagnostic Tests Performed? ▭ YES ▭ NO (check all that apply)
  - ▭ X-ray ▭ MRI ▭ CT-Scan ▭ Neuropsychological Testing ▭ Other
- Have You Ever Been Knocked Out, Become Unconscious, and/or Lost Your Memory Due To A Head Injury / Concussion? ▭ YES ▭ NO
- Please Describe ______________________________
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Head Injury / Concussion? ▭ YES ▭ NO
- Please Describe ______________________________
- Do You Suffer From Headaches? ▭ YES ▭ NO
- How often? ▭ Every Day ▭ 1-2 Times/Week ▭ 1-2 Times/Month
- Where Are Your Headaches Located? ▭ Left Side ▭ Right Side ▭ Front of Head ▭ Back of Head ▭ All Over
- Do You Have A History of Migraine Headaches? ▭ YES ▭ NO
- Have you ever been diagnosed with a learning disability, dyslexia, or ADD/ADHD? ▭ YES ▭ NO

VIII. Cervical Spine / Neck:

- Have You Ever Suffered An Injury To Your Cervical Spine and/or Neck? ▭ YES ▭ NO
- List Date(s) / Time (e.g. practices or games) Missed ______________________________
- Please Describe ______________________________
- Were Any Diagnostic Tests Performed? (check all that apply) ▭ X-Rays ▭ MRI ▭ CT-Scan ▭ Bone Scan
- Have You Ever Had “Burners”, “Stingers”, or Brachial Plexus Injuries? ▭ YES ▭ NO
- How Many? ______________ Date(s)/Time Missed? ______________________________
- Have You Ever Experienced Numbness and/or Tingling in Your Arms/Fingers? ▭ YES ▭ NO
- Have You Ever Had Surgery of Any Kind on Your Cervical Spine / Neck? ▭ YES ▭ NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Cervical Spine / Neck Injury? ▭ YES ▭ NO

  Please provide dates and describe any **YES** answers: ______________________________

XII. Lumbar Spine/ Sacroiliac Joint:

- Have You Ever Suffered An Injury To Your Spine / Low Back / Sacroiliac Joint? ▭ YES ▭ NO
- Were Any Diagnostic Tests Performed? (check all that apply) ▭ X-Rays ▭ MRI ▭ CT-Scan ▭ Bone Scan
- Have You Ever Been Hospitalized For A Spine / Low Back / Sacroiliac Joint Injury? ▭ YES ▭ NO
- Have You Ever Had Surgery of Any Kind on Your Spine / Low Back / Sacroiliac Joint? ▭ YES ▭ NO
- Have You Ever Had Numbness/Tingling Down One (1) or Both Legs? ▭ YES ▭ NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Spine, Low Back, or SI Joint Injury? ▭ YES ▭ NO
- Please describe any **YES** answers: ______________________________

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II. Allergies:

- Have You Ever Been Diagnosed with Seasonal Allergies? ▭ YES ▭ NO
- Are You Presently Taking/Have You Previously Taken Any Allergy Medications? ▭ YES ▭ NO
- Are you allergic to and/or ever had an unfavorable / allergic reaction to any medications? ▭ YES ▭ NO

- Are you allergic to and/or ever had an unfavorable / allergic reaction to any food items? ▭ YES ▭ NO
- Are you allergic to and/or ever had an unfavorable / allergic reaction to bee stings, insect bites, etc.? ▭ YES ▭ NO

Please Describe any **YES** answers: ______________________________

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III. Asthma:

- Have You Ever Been Diagnosed with Asthma and/or Exercised Induced Asthma? ▭ YES ▭ NO
- Are You Presently Taking / Have You Previously Taken Any Asthma Medications / Use an Inhaler? ▭ YES ▭ NO
- Have You Ever Been Hospitalized As a Result of Asthma and/or Exercised Induced Asthma? ▭ YES ▭ NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To Asthma Or Any Related Condition? ▭ YES ▭ NO

Please provide dates and describe any **YES** answers: ______________________________

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VI. Ear / Nose / Throat:

- Have You Ever Suffered An Injury To Your Ear(s), Nose, and/or Throat? ▭ YES ▭ NO
- Have You Ever Been Hospitalized For A Ear, Nose, and/or Throat Injury? ▭ YES ▭ NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Ear, Nose, and/or Throat Injury? ▭ YES ▭ NO

Please provide dates and describe any **YES** answers: : ______________________________

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V. Eye:

- When Was Your Last Eye Exam and were there any abnormal findings? ______________________________
- Have You Ever Suffered An Injury To Your Eye(s) and/or Been Advised That You Have An Eye Disease? ▭ YES ▭ NO
- Have You Ever Been Hospitalized and/or Seen An Ophthalmologist For An Eye Injury? ▭ YES ▭ NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Eye Injury? ▭ YES ▭ NO
- Do you routinely suffer from blurred vision, double vision, tunnel vision, and/or any other abnormal sight? ▭ YES ▭ NO
- Do you routinely wear glasses? ▭ YES ▭ NO
- Do you routinely wear contact lenses? ▭ YES ▭ NO Type ______________________________
- Do you require any special devices / equipment? ▭ YES ▭ NO Type ______________________________
- Please describe any **YES** answers: ______________________________

V. Dental:

- When Was Your Last Dental Exam and were there any abnormal findings? ______________________________
- Have You Ever Suffered An Injury/ been hospitalized for a Mouth, Jaw, and/or Tooth Injury? ▭ YES ▭ NO

Please Describe any **YES** answers: ______________________________

IX. Shoulder / Upper Arm:

- Have You Ever Suffered An Injury To Your Shoulder / Upper Arm? ▭ YES ▭ NO
- Were Any Diagnostic Tests Performed? (check all that apply) ▭ X-Rays ▭ MRI ▭ CT-Scan ▭ Bone Scan
- Have You Ever Been Hospitalized For A Shoulder / Upper Arm Injury? ▭ YES ▭ NO
- Have You Ever Had Surgery of Any Kind on Your Shoulder / Upper Arm? ▭ YES ▭ NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Shoulder / Upper Arm Injury? ▭ YES ▭ NO
- Please Describe any **YES** answers: ______________________________

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X. Elbow / Forearm:

- Have You Ever Suffered An Injury To Your Elbow / Forearm? ▭ YES ▭ NO
- Were Any Diagnostic Tests Performed? (check all that apply) ▭ X-Rays ▭ MRI ▭ CT-Scan ▭ Bone Scan
- Have You Ever Been Hospitalized For An Elbow / Forearm Injury? ▭ YES ▭ NO
- Have You Ever Had Surgery of Any Kind on Your Elbow / Forearm? ▭ YES ▭ NO

- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Elbow / Forearm Injury? ▭ YES ▭ NO
- Please Describe any **YES** answers: ____________________

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X. Wrist, Hand, & Fingers:

- Have You Ever Suffered An Injury To Your Wrist(s), Hand(s), and/or Finger(s)? ▭ YES ▭ NO
- Were Any Diagnostic Tests Performed? (check all that apply) ▭ X-Rays ▭ MRI ▭ CT-Scan ▭ Bone Scan
- Have You Ever Been Hospitalized For A Wrist, Hand, and/or Finger Injury? ▭ YES ▭ NO
- Have You Ever Had Surgery of Any Kind on Your Wrist, Hand, and/or Finger(s)? ▭ YES ▭ NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Wrist, Hand, and/or Finger Injury? ▭ YES ▭ NO
- Please describe any **YES** answers: ____________________

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XIII. Hip / Groin:

- Have You Ever Suffered An Injury To Your Hip / Groin *(including hernias and/or sports hernias)?* ▭ YES ▭ NO
- Were Any Diagnostic Tests Performed? (check all that apply) ▭ X-Rays ▭ MRI ▭ CT-Scan ▭ Bone Scan
- Have You Ever Had Surgery For A Hip / Groin Injury? ▭ YES ▭ NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Hip and/or Groin Injury? ▭ YES ▭ NO
- Please describe any **YES** answers: ____________________

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XIV. Thigh / Hamstring / Quadriceps:

- Have You Ever Suffered An Injury To Your Thigh, Hamstring, and/or Quadriceps? ▭ YES ▭ NO
- Were Any Diagnostic Tests Performed? (check all that apply) ▭ X-Rays ▭ MRI ▭ CT-Scan ▭ Bone Scan
- Have You Ever Been Hospitalized For A Thigh, Hamstring, and/or Quadriceps Injury? ▭ YES ▭ NO
- Have You Ever Had Surgery For A Thigh, Hamstring, and/or Quadriceps Injury? ▭ YES ▭ NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Thigh, Hamstring, or Quadriceps Injury? ▭ YES ▭ NO
- Please describe any **YES** answers: ____________________

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X. Knee / Patella:

- Have You Ever Suffered An Injury To Your Knee and/or Patella (kneecap)? ▭ YES ▭ NO
- Were Any Diagnostic Tests Performed? (check all that apply) ▭ X-Rays ▭ MRI ▭ CT-Scan ▭ Bone Scan
- Have You Ever Been Hospitalized For A Knee and/or Patella Injury? ▭ YES ▭ NO
- Have You Ever Had Surgery For A Knee and/or Patella Injury? ▭ YES ▭ NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Knee / Patella Injury? ▭ YES ▭ NO
- Have You Ever/Do You Presently Wear A Knee Brace? ▭ YES ▭ NO
- Please describe any **YES** answers: ____________________

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XVI. Ankle / Lower Leg:

- Have You Ever Suffered An Injury To Your Ankle / Lower Leg? ▭ YES ▭ NO
- Were Any Diagnostic Tests Performed? (check all that apply) ▭ X-Rays ▭ MRI ▭ CT-Scan ▭ Bone Scan
- Have You Ever Been Hospitalized For An Ankle / Lower Leg Injury? ▭ YES ▭ NO
- Have You Ever Had Surgery For An Ankle / Lower Leg Injury? ▭ YES ▭ NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Ankle / Lower Leg Injury? ▭ YES ▭ NO
- Do You Presently ▭ Tape Your Ankle(s) ▭ Use Ankle Brace(s) ▭ Other
- Please describe any **YES** answers: ____________________

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X. Foot / Toes:

- Have You Ever Suffered An Injury To Your Foot / Toe(s)? ▭ YES ▭ NO
- Were Any Diagnostic Tests Performed? (check all that apply) ▭ X-Rays ▭ MRI ▭ CT-Scan ▭ Bone Scan
- Have You Ever Had Surgery For A Foot / Toe Injury? ▭ YES ▭ NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Foot and/or Toe Injury? ▭ YES ▭ NO
- Please describe any **YES** answers: ______________________________

XXI. Dermatological:

- Do you have any skin problems that we should be aware of (e.g. itching, rashes, acne, warts, eczema, fungus, etc.)? ▭ YES ▭ NO
- Have you ever been under the care of a dermatologist for any condition? ▭ YES ▭ NO
- Have you ever been advised not to participate in athletic activities due to a skin condition? ▭ YES ▭ NO

Please Describe any YES answers: ______________________________

XX. Medical Testing

- Have You Ever Been Diagnosed With A Communicable Disease (e.g. STD, HIV, Hepatitis A, B, or C, Herpes Simplex, Syphyllis, Tuberculosis)?

  ▭ YES ▭ NO
- Please Describe ______________________________

XXII. Prescription Medications:

- Please List **ALL** Prescription & Over-the-Counter Medications That You Are **CURRENTLY** Taking or **Have Taken**
- In The PAST Two (2) Years, & For What Purpose:
- **MEDICATION** **PURPOSE** **DOSAGE** **DATE(S)**

XXIII. Supplements / Ergogenic Aids:

- Please List **ALL** Supplements / Ergogenic Aids That You Are **CURRENTLY** Taking or **Have Taken** In The PAST Two (2)
- Years, & For What Purpose:
- **SUPPLEMENT** **PURPOSE** **DOSAGE** **DATE(S)**

XXIV. Heat Related Problems:

- Have You Ever Suffered from a Heat Related Injury? ▭ YES ▭ NO (check all that apply):
- ▭ Heat Cramps- Date(s)? ______________________________
- ▭ Heat Syncope (Fainting)- Date(s)? ______________________________
- ▭ Heat Exhaustion- Date(s)? ______________________________
- ▭ Heat Stroke- Date(s)? ______________________________
- Have You Ever Received Intravenous Fluids (IV) or been hospitalized For A Heat Related Problem? ▭ YES ▭ NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Heat Related Injury? ▭ YES ▭ NO
- Please Describe any YES answers: ______________________________

XXV. Diabetic History:

- Have You Ever Been Diagnosed With Diabetes? ▭ YES ▭ NO
- Date? ______________________________
- Are You Presently Taking or Have You Taken Any Diabetic Medications? ▭ YES ▭ NO
  - **Medication** **Form** **Dosage** **Frequency**

- Do You Daily Monitor Your Blood Sugar Level? ☐ YES ☐ NO
- How Many Times Per Day? ________________ What Is Your Average Level? ________
- Have You Had Any Hypoglycemic Episodes (low blood sugar) Within The Last Twelve (12) Months? ☐ YES ☐ NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To Diabetes? ☐ YES ☐ NO
- Please List Any Precautions That You Take and/or Additional Information Not Mentioned Above: ________________

XXVI. Sickle Cell Anemia:

- Have you ever been tested for Sickle Cell Anemia that you are aware of? ☐ YES ☐ NO
- Date? ________________ Result? ________________
- Does any member of your family carry the Sickle Cell Trait / have Sickle Cell Anemia that you are aware of? ☐ YES ☐ NO
- Have you ever been advised that you carry the Sickle Cell Trait / have Sickle Cell Anemia? ☐ YES ☐ NO
- Please Describe ________________

XXVII. For Females Only:

At what age did you have your first menstrual period? ________________

Have you had menstrual periods within the past 12 months? ☐ YES ☐ NO

If yes, how many? ________ When was your most recent menstrual period? ________

What was the longest time between menstrual periods within the past year? ________

Do you have painful or heavy menstrual periods? ☐ YES ☐ NO

Do you take any medications during your menstrual periods? ☐ YES ☐ NO

If yes, what? ________________

Do you take birth control pills? ☐ YES ☐ NO

If yes, what brand? ________________

Have you ever had any problems with your breasts? ☐ YES ☐ NO

Have you had a pelvic examination within the last year? ☐ YES ☐ NO

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

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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 understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

Student-Athlete Name (Printed):________________
Student-Athlete Signature:________________ **Today's Date: ________________**

Parent/Guardian Name (Printed): (if athlete under 18 years of age): ________________
Parent/Guardian Signature *(if under 18 years of age)*:________________ **Today's Date: ________________**

Reviewed By:

Reviewer's Signature: Date: