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: _____

_____

_____

_____

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: _____

_____

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: _____

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: _____

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: _____

_____

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: _____

_____

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: : _____

_____

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: _____

  _____

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: _____

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: _____

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: _____

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: _____

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: _____

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: _____

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. ****

_____

_____

_____

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: