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 ever 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 W ith 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
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
- Have 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
  - YES  NO
- 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, Syphilis, 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? (check all that apply):
  - YES  NO
- _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?
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: