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: ________________________________ Date of Birth: ________________ Sport(s): __________________________

Today’s Date: ____________________

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 had 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 Abdominal 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? (check all that apply)    YES  NO
  - 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: 

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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: 

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**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: 

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**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
**X. Wrist, Hand, & Fingers:**
- Have You Ever Suffered An Injury To Your Wrist(s), Hand(s), and/or Finger(s)?
- 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?
- Have You Ever Had Surgery of Any Kind on Your Wrist, Hand, and/or Finger(s)?
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Wrist, Hand, and/or Finger Injury?
- Please describe any YES answers:

**XIII. Hip / Groin:**
- Have You Ever Suffered An Injury To Your Hip / Groin (including hernias and/or sports hernias)?
- 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?
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Hip and/or Groin Injury?
- Please describe any YES answers:

**XIV. Thigh / Hamstring / Quadriceps:**
- Have You Ever Suffered An Injury To Your Thigh, Hamstring, and/or Quadriceps?
- 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?
- Have You Ever Had Surgery For A Thigh, Hamstring, and/or Quadriceps Injury?
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Thigh, Hamstring, or Quadriceps Injury?
- Please describe any YES answers:

**X. Knee / Patella:**
- Have You Ever Suffered An Injury To Your Knee and/or Patella (kneecap)?
- 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?
- Have You Ever Had Surgery For A Knee and/or Patella Injury?
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Knee / Patella Injury?
- Have You Ever/Do You Presently Wear A Knee Brace?
- Please describe any YES answers:

**XVI. Ankle / Lower Leg:**
- Have You Ever Suffered An Injury To Your Ankle / Lower Leg?
- 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?
- Have You Ever Had Surgery For An Ankle / Lower Leg Injury?
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Ankle / Lower Leg Injury?
- 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, 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:
  
<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>PURPOSE</th>
<th>DOSAGE</th>
<th>DATE(S)</th>
</tr>
</thead>
</table>

**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:
  
<table>
<thead>
<tr>
<th>SUPPLEMENT</th>
<th>PURPOSE</th>
<th>DOSAGE</th>
<th>DATE(S)</th>
</tr>
</thead>
</table>

**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):__________________________________________  Today’s Date:________________________
Student-Athlete Signature:______________________________________________

Parent/Guardian Name (Printed): (if athlete under 18 years of age):__________________________  Today’s Date:________________________
Parent/Guardian Signature (if under 18 years of age):__________________________  Today’s Date:________________________

Reviewed By:__________________________________________
Reviewer’s Signature:__________________________________________  Date:________________________