Fairmont State University
Student Athlete Medical History Questionnaire

This form will be kept **CONFIDENTIAL**, and will be used as supplementary interpation by the examining physicians and athletic trainers.

Date of Physical _____
Name_____ Age_____ Height_____ Weight _____

Birth date _____ Social Security # _____
School Address _____
_____
School Phone # _____
Parents or Guardian _____
Home Address _____
City _____
State _____ Zip _____ Phone _____

I am a candidate for the _____ team / squad

Medical History; (circle and / or check appropriate answer)

Disease or Illnesses

Yes No 1. Have you ever been treated for the following in the past 12 months?

Infectious mononucleosis _____ date _____
Virus Pneumonia _____ date _____
Other infectious diseases (measles, mumps)_____ date _____

Yes No 2. Have you ever been treated for an asthma attack?

If yes answer to question 2 is yes, what usually brings on an attack?
_____
Medication _____

Yes No 3. Do you carry an inhaler when you participate in an activity?

Yes No 4. Have you ever been treated or informed by a medical doctor that you have rheumatic fever? _____ date_____

Yes No 5. Have you ever been treated or informed by a medical doctor that you have scarlet fever? _____ date_____

Yes No 6. Have you ever been told that you have a heart murmur?
_____ date _____

Yes No 7. Have you ever been treated for any other heart condition?
If so give details _____

Yes No 8. Have you ever experienced an epileptic seizure or been informed that you Might have epilepsy? _____ date_____

Yes No 9. If the answer to question # 8 is yes, are your seizures controlled by medication?
Name of Medication _____

Yes No 10. Have you had hepatitis during the past three years?
If yes give date _____

Yes No 11. Have you ever taken medication to regulate you BLOOD PRESSURE?
If so give details.
Name of Medication _____

Yes No 12. Have you ever been treated for diabetes?

Yes No 13. If the answer to question # 12 is yes, how is it regulated ?
Injections _____ times / day _____
Exercise _____
Diet _____

Yes No 14. Have you ever been informed by a medical doctor that you have sickle cell anemia ? date_____

Yes No 15. Have you had any illness requiring bed rest of one week or longer during the past year ? Nature of Illness _____

Yes No 16. Have you had a tetanus shot in the last 5 years ? date _____

Yes No 17. Have you ever been "knocked out" or experienced a concussion during the last three years? If yes, give date(s) _____

Yes No 18. If the answer to question # 17 is yes, have you been "knocked out" more than once? How many times _____ date _____

Yes No 19. If the answers to question # 17 & # 18 are yes, did the attending physician have you stay overnight in the hospital?
Details _____
_____

Yes No 20. Have you ever experienced seizures after a head injury?
Details _____ dates _____

Yes No 21. Have you ever had any of the following?
Strained neck _____ date _____
Sprained neck _____ date_____
Fractured neck _____ date _____
Pinched nerve _____ date _____
Whiplash _____ date _____
Severe headaches _____ date_____
Other _____ date _____

Eyes & Dental

Yes No 22. Do you have vision in both eyes?

If the answer to question #22 is no, give the details _____
_____

Yes No 23. Do you wear contact lenses? _____ hard _____ soft

Yes No 24. Do you wear eye glasses? _____ regular
_____ safety lens frames

Yes No 25. If the answer to question # 23 and / or # 24 is yes, do you wear them during athletic competition? Specify if yes to both # 23 & # 24 _____

Yes No 26. Do you wear any of the following appliances?

_____ permanent bridge
_____ permanent crown or jacket
_____ removable partial
_____ full plate
_____ braces

Yes No 27. Do you have any dead teeth?
If yes, please indicate approximate location _____

Bones & Joints

PLEASE INDICATE LEFT (L) OR RIGHT (R) FOR ANY INJURIES YOU RECEIVED DURING PAST FIVE YEARS.

Yes No 28. Have you had a fracture during the past three years?
Site _____ date_____

Yes No 29. Do you currently have any incompletely healed injuries. If so give details
_____
_____
_____
_____

SHOULDER:

Yes No 30. Have you had a shoulder or throwing arm injury during the past three years that incapacitated you?

Dislocation R_____ L_____ dates_____
Partial dislocation R _____ L _____ dates _____
Rotator cuff strain R _____ L _____ dates _____
Muscular strain R _____ L _____ dates _____
Biceps tendonitis R _____ L _____ date _____

Bursitis R _____ L _____ date _____
Separation R _____ L _____ date _____
Other R _____ L_____ date _____

Yes No 31. Have you ever been advised to have surgery to correct a shoulder condition?
Details _____
_____
_____
Date _____

Yes No 32. If the answer to question # 31 is yes, has the surgery been completed?
Details _____
_____
_____
Date _____

Elbow:

Yes No 33. Have you experienced an elbow injury during the past three years that incapacitated you?
Severe sprain / strain R _____ L _____ date_____
Hyperextension R _____ L _____ date _____
Dislocation R _____ L _____ date _____
Fracture R _____ L _____ date _____
Tennis Elbow R _____ L _____ date _____
Other: _____
_____

Yes No 34. Have you had any surgery on the elbow in the past three years ?
If yes, condition _____
_____
dates _____

Wrist:

Yes No 35. Have you experienced a wrist injury during the past three years that incapacitated you?
Muscular strain R _____ L _____ date _____
Sprain R _____ L _____ date _____
Navicular fracture R _____ L _____ date _____
Colles' fracture R _____ L _____ date _____
Dislocation of Lunate R _____ L _____ date _____
Wrist ganglion R _____ L _____ date _____
Other _____ date _____

Yes No 36. Have you had surgery on the wrist or hand in the past three years?
If yes, condition _____
_____
_____

Back:

Yes No 37. Have you ever had an injury to your back?

Muscular Strain _____ date_____
Lumbosacral sprain _____ date _____
Sacroiliac sprain _____ date _____
Sciatic nerve involvement _____ date _____
Disc injury _____ date _____
Kidney injury _____ date _____
Spindolosis / spondolysthesis _____ date _____

Yes No 38. If the answer to question # 30 is yes, did you seek the advice or care or medical doctor ?

Yes No 39. Have you had any surgery performed on your back?

Yes No 40. Do you experience pain in the back? If yes , condition _____
Date _____
_____ very seldom
_____ occasionally
_____ frequently
_____ only following vigorous exercise

Yes No 41. Have you ever been told that you have scoliosis?

Yes No 42. If so is it structural or functional? And what treatment was recommended?

Yes No 43. Have you ever been told that you have kyphosis or lordosis?

Knee:

Yes No 44. Have you experienced a sprain during the past three years of either knee with severe swelling accompanying the injury?

Yes No 45. Have you ever been told that you injured the ligaments in either knee?
Date_____
_____ Medial
_____ Lateral

Yes No 46. Have you ever been told that injured the cartilage in either knee?
Date _____
_____ Medial
_____ Lateral

Yes No 47. Have you ever experienced pain or a grating (crackling) sensation behind your kneecap ? date _____

Yes No 48. Have you ever been advised to have surgery on a knee to correct a condition?
Date_____

Yes No 49. Have you ever been told you have had Osgood-Schlatter's disease?
Date_____

Yes No 50. If the answer to question # 49 is yes, has the surgery been completed?
Details _____
_____
_____
Date _____

ANKLE:

Yes No 51 Have you ever experienced an ankle injury during the past three years that incapacitated you?

Sprain _____ outside _____ inside _____ date _____
Torn ligament _____ date _____
Dislocation _____ date _____
Fracture _____ date _____

Yes No 52. Do you have a pin, screw or plate somewhere in your body as a result of bone or joint surgery?
General site _____
Date or surgery _____

GENERAL:

Yes No 53. Have you ever been treated for kidney stones?

Yes No 54. Are you missing a paired organ (e.g. kidney, eye, testicle ect.)
Details _____
_____
_____
_____

Yes No 55. Have you had any additional operation during the past three years?
Site _____ Date _____

Yes No 56. Have you ever been told that you have a hernia?
If yes, give details _____
_____
_____
Location:_____ date _____

Yes No 57. If answer to # 56 is yes, has surgery been preformed to correct the problem?
Date _____

Yes No 58. Have you had your appendix removed?
Date _____

Yes No 59. Are you currently on prescribed medication or drugs on a permanent or semi-permanent basis? If so, indicate the name the drug and for what it is prescribed.

Drug name _____
Why prescribed _____

Yes No 60. Are you allergic to any medication? (Example: aspirin, sulfa drugs, etc.)
If yes, please give details.
Medications_____
_____
_____
_____

Yes No 61. Are you allergic to insect bites? Specify insect _____
If yes, what has happened with you last insect bite? _____
_____
_____
_____

Yes No 62. Do you have a hearing loss in either ear?
If yes, give details _____
_____
_____

Yes No 63. Do you suffer from severe menstrual cramps?
If yes, what eases the discomfort? _____
_____
_____

Yes No 64. Have you ever been treated for toxic shock syndrome ?

Yes No 65. Has your weight fluctuated 20 pounds or more in the past year?
If so give details _____
_____
_____
_____

I confirm that all of the above questions have been answered completely and truthfully to the best of my knowledge.

Signature of Athlete:_____

Signature of Parents or Guardian:_____