



Athletic Training Department Health History Questionnaire

Please note that prior to intercollegiate participation this form must be filled out in its entirety and returned to the Athletic Training Department.

Name _____	Student ID# _____
Date of Birth _____	Year in School: Fr Soph Jr Sr
Sport(s) _____	

Annual Vitals: (Athletic Training Staff only)

Blood Pressure
Height
Weight
Arm Span

Circle yes or no; answer questions accordingly

ORTHOPEDIC HISTORY

Head Injury/Concussion	Yes	No
<ul style="list-style-type: none"> • List dates/times missed: • Describe injury 		
Have you ever been knocked out, hospitalized, became unconscious, or lost your memory due to head injury?	Yes	No
<ul style="list-style-type: none"> • Were any diagnostic tests performed? 	Yes	No
Do you suffer from headaches?	Yes	No
<ul style="list-style-type: none"> • How often? • Where are they located? 		
Do you have a history of migraines?	Yes	No
<ul style="list-style-type: none"> • How often? • Where are they located? 		
Do you have epilepsy?	Yes	No
<ul style="list-style-type: none"> • If yes, please explain. 		

Missing Organs

List:	Yes	No
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ORTHOPEDIC HISTORY CONTINUED

Cervical Spine/Neck Injury				Yes	No
• List dates/times missed.					
• Describe injury					
• Were any diagnostic tests performed?	X-ray	MRI	Other_____		
• Were you hospitalized?					
• Have you ever had surgery on your neck?				Yes	No
Have you ever had a "burner", "stinger", or any brachial plexus injury?				Yes	No
• List dates/times missed.					
• How many?					
• Have you ever worn or been advised to wear a neck collar, or any other restrictive device?				Yes	No
Shoulder/Upper Arm Injury	Right / Left			Yes	No
• Describe					
• Were any diagnostic tests performed?	X-ray	MRI	Other_____		
• Have you had past surgeries?				Yes	No
• Explain					
Elbow/Forearm Injury	Right / Left			Yes	No
• Describe					
• Were any diagnostic tests performed?	X-ray	MRI	Other_____		
• Have you had past surgeries?				Yes	No
• Explain					
Wrist/Hand Injury	Right / Left			Yes	No
• Describe					
• Were any diagnostic tests performed?	X-ray	MRI	Other_____		
• Have you had past surgeries?				Yes	No
• Explain					
Spine/Lower Back/Sacroiliac Joint Injury	Right / Left			Yes	No
• Describe					
• Were any diagnostic tests performed?	X-ray	MRI	Other_____		
• Have you had past surgeries?				Yes	No
• Explain					
• Have you ever experienced numbness or pain down one or both legs?				Yes	No
• Explain					
Ribs/Thorax/Chest Injury	Right / Left			Yes	No
• Describe					
• Were any diagnostic tests performed?	X-ray	MRI	Other_____		
• Have you had past surgeries?				Yes	No
• Explain					
Hip/Groin Injury	Right / Left			Yes	No
• Describe					
• Were any diagnostic tests performed?	X-ray	MRI	Other_____		
• Have you had past surgeries?				Yes	No
• Explain					
Thigh/Knee Injury	Right / Left			Yes	No
• Describe					
• Were any diagnostic tests performed?	X-ray	MRI	Other_____		
• Have you had past surgeries?				Yes	No
• Explain					
Ankle/Lower Leg Injury	Right / Left			Yes	No
• Describe					
• Were any diagnostic tests performed?	X-ray	MRI	Other_____		
• Have you had past surgeries?				Yes	No
• Explain					

Foot/Toe Injury	Right / Left	Yes	No
<ul style="list-style-type: none"> Describe 			
<ul style="list-style-type: none"> Were any diagnostic tests performed? 		X-ray	MRI
<ul style="list-style-type: none"> Have you had past surgeries? 		Other	
		Yes	No
<ul style="list-style-type: none"> Explain 			

GENERAL MEDICAL CONCERNS

General Medical			
<ul style="list-style-type: none"> Have you ever been tested for HIV/AIDS? 		Result: Positive / Negative	No
<ul style="list-style-type: none"> Have you ever contracted any type of Hepatitis? 		Type: A B C	No
<ul style="list-style-type: none"> Have you ever been tested for sickle cell anemia? 		Result: Positive / Negative	No
<ul style="list-style-type: none"> Have you had a positive test for a MRSA skin infection? 		Yes	No

Heat-related Problems			
<ul style="list-style-type: none"> Have you experienced heat cramps? 		Yes	No
<ul style="list-style-type: none"> Have you experienced heat exhaustion? 		Yes	No
<ul style="list-style-type: none"> Have you experienced heat stroke? 		Yes	No
<ul style="list-style-type: none"> Have you received intravenous fluids for a heat related problem? 		Yes	No
<ul style="list-style-type: none"> Have you been hospitalized for a heat related problem? 		Yes	No

Allergies			
<ul style="list-style-type: none"> Have you been diagnosed with food, drug, or latex allergies? 		Yes	No
<ul style="list-style-type: none"> List: 			
<ul style="list-style-type: none"> Do you take allergy medications? 		Yes	No
<ul style="list-style-type: none"> Are you allergic to insect stings or bites? 		Yes	No

Asthma			
<ul style="list-style-type: none"> Do you have asthma or exercise induced asthma? 		Yes	No
<ul style="list-style-type: none"> Describe 			
<ul style="list-style-type: none"> Do you take asthma medications? 		Yes	No

Diabetic History			
<ul style="list-style-type: none"> Have you been diagnosed with diabetes? 		Type 1	Type 2
<ul style="list-style-type: none"> List of medication dose and schedule: 			
<ul style="list-style-type: none"> Do you use an insulin pump? 		Yes	No
<ul style="list-style-type: none"> Describe your schedule of testing blood sugars 			
<ul style="list-style-type: none"> List any precautions that you take or any additional information needed 			
<ul style="list-style-type: none"> Most recent HgbA1C level 		%	Date:

Cardiovascular			
<ul style="list-style-type: none"> Have you ever had chest pain/shortness of breath during or after exercise? 		Yes	No
<ul style="list-style-type: none"> Have you ever felt dizzy, lightheaded, and/or passed out during or after exercise? 		Yes	No
<ul style="list-style-type: none"> Have you ever had the feeling of your heart racing or skipping beats during or after exercise? 		Yes	No
<ul style="list-style-type: none"> Have you ever been told that you have a heart murmur? 		Yes	No
<ul style="list-style-type: none"> Has a physician ever restricted your participation in sports due to a heart condition? 		Yes	No
<ul style="list-style-type: none"> Has a physician ordered an electrocardiogram (EKG) of your heart? 		Yes	No
<ul style="list-style-type: none"> Do you have high blood pressure? 		Yes	No
<ul style="list-style-type: none"> Do either of your parents have high blood pressure and/or take medication? 		Yes	No
<ul style="list-style-type: none"> Has any family member died of heart problems or sudden death before the age of 35? 		Yes	No

Body Composition/Nutrition			
• Have you had an undesired weight change (loss or gain) of greater than 10 pounds in the last year?	Yes	No	
• Do you regularly lose weight to participate in your sports?	Yes	No	
• Do you want to weigh less or more than you presently do?	More	Same	Less
• Have you previously or do you currently have anorexia or bulimia?	Yes	No	
• Are you a vegetarian? If yes, provide type:		No	
• Have you ever felt forced to limit your food intake?	Yes	No	
• Are you currently taking any vitamins? (if yes, list below)		No	
• Are you currently taking any supplements? (if yes, list below)		No	

Dermatological / other	
• Do you have any skin problems? (If yes, explain)	No
• Are you currently under the care of a physician for any medical condition? (If yes, explain)	No
• Do you have a chronic illness? (If yes, explain)	No
• Have you ever been hospitalized overnight? (If yes, explain)	No
• Have you ever been under the care of a psychiatrist or psychologist? (If yes, explain)	No

Female Athletes Only		
• When was your first menstrual period?		
• How many menstrual periods have you had in the last 12 months?		
• When was your most recent menstrual period?		
• Do you have heavy or painful menstrual periods?	Yes	No
• Do you take medication during your menstrual periods?	Yes	No
• Have you ever had any problems with your breasts? (If yes, explain)		No
• Have you had a pelvic exam within the last 12 months?	Yes	No
• Are you currently pregnant?	Yes	No
• Do you take birth control? (if yes, list below)		No

Please list all medications you are currently taking:

Do you know or do you believe there is any health reason you should not participate in the Beloit College intercollegiate athletic program? YES NO

Have you ever been advised by a medical doctor not to participate in the sport in which you are now planning to participate? YES NO

All of the questions on the previous pages have been answered completely and truthfully to the best of my knowledge.

Student–Athlete Signature

Date

Guardian Signature (if under 18 years old)

Date