OLD DOMINION UNIVERSITY
FIRST YEAR MEDICAL HISTORY QUESTIONNAIRE
INTERCOLLEGIATE ATHLETICS

NAME:_____ **BIRTH DATE**:_____
TODAY'S DATE:_____**SPORT**: _____

Instructions: The below information is necessary in order for the athletic training/medical staff to have a basic knowledge of those conditions, injuries, etc. that you have had in the past or may be affecting you at present. Please read all questions carefully and respond as directed. Be as specific as possible wherever and whenever possible. The contents of this form will be kept <u>confidential</u> by the athletic training department and will be used as supplementary information by the examining physicians and athletic trainers.

General Medical History

1. ***How many years has it been since your last <u>complete</u> health examination, other than an exam required for participation in sports?***

O 1 year **O** 2 year **O** 3 year **O** >3 years

O Have never had a complete health examination other than for athletics.

2. ***Are you presently taking any prescribed or over the counter medication? (Including birth control pills, insulin, allergy shots or pills, asthma inhalers, epilepsy medication, anti-inflammatory medication, supplements of any kind. etc.)***

O Yes (If yes, please fill out below.)

O No

Name of Medication	*Dose*	*Frequency of use*

3. ***Do you have an allergy to any of the following?***

	Yes	*No*	*Specify Allergy*
drug or medicine (over the counter/ prescribed)			
foods			
insect or animals			
plants, grasses, pollen, dust, etc.			
other (please specify)			

4. ***Has a doctor ever told you that you have/had any of the following medical problems?***

	Yes	*No*		*Yes*	*No*
mononucleosis			**stomach or intestinal ulcer**		
rubella (German Measles)			**hernia**		
chicken pox			**diabetes**		
hearing defect or loss			**anemia**		

epilepsy			**abnormal bleeding or clotting disorder**		
tumor, growth, cyst, cancer			**blood clot or embolism**		
over-active thyroid			**leukemia or other blood disorders**		
under-active thyroid			**blood in urine**		
arthritis			**kidney injury**		
Marfan syndrome			**other kidney disease**		
other heart abnormality			**frequent urinary tract infections**		
oral herpes (cold sores)			**depression**		
genital herpes			**other mental disorder**		
injury to liver or spleen			**birth defect**		
hepatitis			**other (please specify)**		

5. ***Have you ever had surgery to any of the following?***

	Yes	*No*	*Date*	*If yes, reason for surgery:*
eyes				
ears/nose/throat				
heart				
lungs				
Stomach/bowels/appendix				
kidneys				
liver/spleen				
bone				
muscle/ligament/tendon				
joint				
other (please specify)				

6. ***Were you born with two normal:***

	Yes	*No*	*If no, please specify abnormality:*
eyes			
ears			
kidney			

7. ***Do you presently have any of the following skin problems?***

	Yes	*No*
rash		
fungal infection		
cold sore(s)		

8. ***Have you ever had heat exhaustion/heat stroke/sun stroke?*** **O** Yes **O** No

--If yes, please provide details:_____

_____

9. ***During or after exercise, have you ever:***

	Yes	*No*		*Yes*	*No*
been dizzy or light-headed?			**found it more difficult to breath than usual?**		
passed out (fainted)?			**had problems with coughing?**		
had chest pain/discomfort or tightness?					

--If yes, please provide details:_____
_____

10. ***Have you ever been told that you have a heart murmur?*** **O** Yes **O** No

--If yes, have you ever been held out of competition due to the murmur? **O** Yes **O** No

11. ***Have you ever been told by a doctor that you had or have:***

	Yes	*No*
high blood pressure?		
pericarditis, myocarditis, endocarditis (infections of the heart)?		
rheumatic fever?		
Other heart or vascular problems? (please specify in space below)		

12. ***Have you ever had any medical tests for your heart (i.e. EKG, echocardiogram)?***

O Yes (***If yes, please specify test and reason below***.)
O No

Test	*Date*	*Reason*

13. ***Have you ever had any of the below listed conditions?***

	Yes	*No*		*Yes*	*No*
bronchitis			wheezing that starts during or just after exercise		
tuberculosis			pneumothorax (collapsed lung)		
asthma					

--If you have asthma, do you carry an inhaler? **O** Yes **O** No
--How often?_____

14. ***Have you ever had a head injury resulting in any of the following symptoms:***

-dizziness, nausea, headache, confusion, loss of consciousness, memory loss
O Yes (**How many times? O** 1x **O** 2x **O** 3x **O** 4x **O** >4x**)**
O No

15. ***If yes, please answer the following questions:***

Please give approximate date or dates when this occurred:_____
Did you miss any practice or games? **O Yes O No**
--If yes, how long were you out of practice or games? _____
Did you go to the hospital for evaluation? **O Yes O No**
--If yes, what tests were performed?_____

Have you ever had any long-term problems due to the head injury (i.e. memory loss, headaches, seizures, lack of concentration)? O Yes O No

--If yes, what are/were the effects?_____

16. ***Have you ever had any symptoms of numbness, tingling or weakness in your:***

	Yes	*No*
shoulders/arms/hands?		
buttocks?		
legs/feet?		

--If yes, please provide details:_____

17. ***Have you ever had a seizure?*** **O** Yes **O** No

--If yes, please provide details:_____

18. ***Do you experience migraine headaches?*** **O** Yes **O** No

--If yes, please provide details:_____

19. ***Have you ever had a serious eye injury?*** **O** Yes **O** No

--If yes, please provide details:_____

20. ***Do you have vision in both eyes?*** **O** Yes **O** No

--If no, please provide details:_____

21. ***Are you legally blind in either of your eyes?*** **O** Yes **O** No

--If yes, please provide details:_____

22. Do you wear contact lenses during practice or competition? **O** Yes **O** No

23. ***Do you wear any of the following dental appliances?***

	Yes *Yes*	**No** *No*		**Yes** *Yes*	**No** *No*
permanent bridge			**full plate**		
permanent crown			**braces**		
removable partial			**other (please specify)**		

24. ***Have you ever suffered from or are you currently suffering from Temporal Mandibular Joint Syndrome (TMJ)?*** **O** Yes **O** No

25. Do you have sickle cell anemia or sickle cell trait? **O** Yes **O** No **O** Unknown

<u>Women Only</u>, Men to Question #29

26. ***When was your most recent menstrual period?***

O <1 month **O** 1-3 months **O** 4-6 months **O** >6 months

27. ***In the past 12 months:***

	Yes	**No**
have you had trouble with heavy menstrual bleeding?		
have you had bleeding between periods?		
have you had menstrual cramps or pain which affected your school or athletic performance?		

have you had any discharge from your vagina?		
how many periods have you had? O none O 1-3 O 4-6 O 7-12 O >12		
longest time between periods? O <1 month O 1-3 months O 4-6 months O >6 months		
on average how long has each period lasted? O 1-5 days O 6-10 days O 11-15 days O >15 days		

28. ***Would you like to discuss with the medical staff any gynecological problems you may have*****?**

O Yes

O No

***Men Only, Women to Question* #31**

29. Were you born with two normal testicles? **O** Yes **O** No

30. Have you ever had surgery to remove or repair a testicle? **O** Yes **O** No

--If so please provide details:_____

Orthopedic History

Please indicate whether or not you have had an injury or problem within the past 3 years with any of the of the following listed conditions. Please be specific, where indicated, as to right (R) or left (L) side.

31. NECK:

	R	*L*	*Yes*	*No*		*R*	*L*	*Yes*	*No*
disc disease					**strain/sprain**				
traumatic fracture					**surgery**				
stress fracture					**burner/stinger**				
whiplash					**other (please specify)**				

--If yes, please provide details**:**_____

_____

32. SPINE/BACK:

	R	*L*	*Yes*	*No*		*R*	*L*	*Yes*	*No*
congenital deformity/birth defect					**spondylolisthesis (slipped vertebra)**				
traumatic fracture					**disc disease**				
stress fracture					**sacroiliac dysfunction**				
back pain					**sciatica**				
back stiffness					**scoliosis**				
spondylolysis					**surgery**				
other (please specify)									

--If yes, please provide details**:**_____

_____

33. SHOULDER:

	R	*L*	*Yes*	*No*		*R*	*L*	*Yes*	*No*
traumatic fracture					**muscle strain**				
bursitis					**subluxation**				
acromioclavicular (AC) separation					**dislocation**				
tendonitis					**instability**				
impingement					**surgery**				
other (please specify)									

***--If yes, please provide details*:**_____
_____

34. ELBOW:

	R	*L*	*Yes*	*No*		*R*	*L*	*Yes*	*No*
traumatic fracture					**muscle strain**				
ligament injury					**dislocation**				
tennis elbow/golfer's elbow					**surgery**				
bursitis					**other (please specify)**				

***--If yes, please provide details*:**_____
_____

35. HAND/WRIST/FINGERS:

	R	*L*	*Yes*	*No*		*R*	*L*	*Yes*	*No*
traumatic fracture					**tendonitis**				
stress fracture					**ganglion**				
ligament injury					**dislocation**				
tendon injury					**surgery**				
other (please specify)									

***--If yes, please provide details*:**_____
_____

36. PELVIS/HIP:

	R	*L*	*Yes*	*No*		*R*	*L*	*Yes*	*No*
traumatic fracture					**tendonitis**				
stress fracture					**contusion/hip pointer**				
groin strain					**glenoid labrum tear**				
dislocation					**surgery**				
other (please specify)									

***--If yes, please provide details*:**_____
_____

37. THIGH:

	R	*L*	*Yes*	*No*		*R*	*L*	*Yes*	*No*
traumatic fracture					**hamstring strain**				
stress fracture					**quadriceps strain**				
tendonitis					**severe contusion**				
bursitis					**surgery**				
other (please specify)									

***--If yes, please provide details*:**_____
_____

38. KNEE:

	R	*L*	*Yes*	*No*		*R*	*L*	*Yes*	*No*
meniscal injury					**catching, giving way, instability feeling**				
PCL tear					**locking**				
ACL tear					**knee dislocation**				
iliotibial band syndrome					**knee cap (patella) disclocation**				
collateral ligament injury					**swelling**				
tendonitis					**unexplained pain**				
bursitis					**surgery**				
pain around the knee cap					**other (please specify)**				

***--If yes, please provide details*:**_____
_____

39. LOWER LEG:

	R	*L*	*Yes*	*No*		*R*	*L*	*Yes*	*No*
traumatic fracture					**compartment syndrome**				
stress fracture					**shin splints**				
muscle strain					**surgery**				
other (please specify)									

***--If yes, please provide details*:**_____
_____

40. ANKLE:

	R	*L*	*Yes*	*No*		*R*	*L*	*Yes*	*No*
traumatic fracture					**instability**				
stress fracture					**bone chip in joint**				
sprain					**bony dislocation/subluxation**				
tendonitis					**tendon dislocation/subluxation**				
bursitis					**surgery**				
other (please specify)									

***--If yes, please provide details*:**_____

_____

41. FOOT/TOES:

	R	*L*	*Yes*	*No*		*R*	*L*	*Yes*	*No*
traumatic fracture					**bone spur**				
stress fracture					**plantar fasciitis**				
sprain					**tendon disclocation/sublxation**				
tendonitis					**bony dislocation/subluxation**				
other (please specify)					**surgery**				

***--If yes, please provide details*:**_____

_____

42. ***In the <u>past 5 years</u>, have you been treated for a serious injury(s) not mentioned above?***

O Yes (If yes, please specify below.)

O No

Specify Injury(s)	*Date*

OLD DOMINION UNIVERSITY ATHLETIC TRAINING DEPARTMENT ASSUMPTION OF RISK STATEMENT

I, _____, am aware of and accept the risk of serious injury that may render me disabled or paralyzed as a result of the intercollegiate sport(s) in which I will be participating. I will do my part to reduce the injury risk by keeping myself in the best possible condition and will follow the advice of the team physician(s), athletic trainers, and health clinic personnel concerning the prevention, treatment, rehabilitation and maintenance of any athletic injury.

All of the questions in this form have been answered completely and truthfully to the best of my knowledge.

Signature of Athlete:_____ **Date**:_____