

NORTHWEST UNIVERSITY MEDICAL HISTORY QUESTIONNAIRE

All Information is Confidential

Name:	Date of Birth:	Year in School:	Phone #: ()	Sport:

Please circle the following as to "yes" or "no", then answer under comments as to DATE, LEFT or RIGHT, EXTENT OF CONDITION.

PAST INJURIES

COMMENTS

- No Yes 1. Head Injuries/Concussion? How many? _____
When? _____
- No Yes 2. Eye/Ear/Nose injury? _____
- No Yes 3. Neck injuries? (Pinched nerves, stinger, etc.) _____
- No Yes 4. Shoulder/Clavicle injuries? (dislocation, separation, fracture) _____
- No Yes 5. Arm/Elbow/Wrist/Hand/Finger injuries? _____
- No Yes 6. Back injury? _____
- No Yes 7. Chest/Abdominal internal or external injuries? _____
- No Yes 8. Hip/Thigh/Leg injuries? _____
- No Yes 9. Knee injuries? (surgery, locking, giving way) _____
- No Yes 10. Ankle injuries? (surgery, sprains, fracture) _____
- No Yes 11. Foot-arch-toe injuries? _____
- No Yes 12. Do you have nay incompletely healed injuries? _____
- No Yes 13. Has anyone ever recommended that you tape or wear a protective brace when participating in sports? _____
- No Yes 14. Any other injuries or recurrent nagging pains? _____

PAST ILLNESSES OR MEDICAL PROBLEMS

- No Yes 15. Pneumonia? _____
- No Yes 16. Heart murmur/disorder? _____
- No Yes 17. Palpitation or pounding heart? _____
- No Yes 18. High blood pressure? _____
- No Yes 19. Diabetes? _____
- No Yes 20. Any allergies: (asthma, Hay fever, bee sting, medications)? _____
- No Yes 21. Skin disorder? _____
- No Yes 22. Kidney disorders? _____
- No Yes 23. Fainting spells or dizziness? _____
- No Yes 24. Epilepsy/convulsive disorders? _____
- No Yes 25. Do you wear glasses or contacts for athletics? Hard or soft lenses? _____
- No Yes 26. Do you take any drugs, vitamins or food supplements? _____
- No Yes 27. Ever had an ulcer? _____
- No Yes 28. Ever had surgery? What kind? _____
- No Yes 29. Ever had mononucleosis? _____
- No Yes 30. Ever had hepatitis? _____
- No Yes 31. Has there been a history of sudden deaths in your family? _____
- No Yes 32. Are you missing one of a paired organ; e.g. eyes, kidney? _____
- No Yes 33. Any current prescription medication(s)? _____
- No Yes 34. Has your weight changed recently? _____
- No Yes 35. Do you feel that you should gain or lose weight? If so, what would you consider your ideal weight to be? Ideal weight: _____ Current weight: _____
- No Yes 36. When was your last tetanus shot? _____
- No Yes 37. Do you smoke? How much? _____
- No Yes 38. Do you drink alcohol? How much? _____
- No Yes 39. Have you ever taken cocaine, marijuana, or other drugs not prescribed by your doctor? (what, when, how often?) _____

No Yes 40. Have you ever NOT been allowed to participate in a sport because of a medical condition? _____

No Yes 41. Do you have to stop when running a half-mile (twice around the track)? _____

No Yes 42. Do you get short of breath cough, or wheeze when exercising? If so, how long does it take to induce these symptoms? _____

No Yes 43. Have you been ill in the last month? _____

44. Has anyone in your family had any of the following? If "yes" please circle and explain.

- a. Heart disease before age 50
- b. hypertension
- c. diabetes
- d. stroke before age 60
- e. hay fever or asthma
- f. alcohol or drug use
- g. bleeding problems
- h. anemia
- i. TB
- j. sickle cell disease
- k. depression
- l. cancer
- m. birth defect/inherited disorder
- n. died of unexplained cause before age 50
- o. osteoporosis
- p. elevated cholesterol

45. Do you have recurrent aches or pains? Circle positives: Headaches? Chest pain? Abdominal pain? Neck or back pain? Muscle or joint pains? If so, how long has this been a problem for you? _____

46. What is your regular exercise pattern? (activity, frequency, duration, intensity) _____

47. What was your most recent dental visit? (mo/yr.) _____

48. Rate your level of stress: a) none or slight b) moderate c) high d) very high

49. Have you ever had any of the following conditions or symptoms? If "yes" circle positive and explain.

Anemia	Bleeding Problems	Eyes (vision) problems	Achilles tendonitis
Ear (hearing) problems	Asthma or Hay fever	Sinusitis	Shoulder problems
Chest pain with exercise	Blood Transfusion	Thyroid disease	Stress fractures
Arthritis	Testicular problems	Numbness or tingling	Elbow pain
Knee pain	Jumpers knee	Chondromalacia	Pain in feet
Osgood Schlatters	Joint instability	Shin splints	Ankle problems

Explain: _____

50. Is there anything else that you would like to discuss with the doctor or athletic trainers? Yes/No _____

For Women Only

Menstrual history: Age onset _____ Interval between periods _____ Duration _____

Regular or Irregular? If irregular, give month of last three periods _____

Discomfort (circle one) None/slight Moderate Severe

I hereby state that I have fully and completely disclosed and described every part of my medical history of which I have knowledge. Further, I have fully and completely disclosed any and all past and preexisting injuries, congenital defects, and any and all ailments that would potentially cause me to be unable to perform as a player. As to all of the above which I have not made full and complete disclosure, I hereby waive my rights to any and all claims against Northwest University, the Athletic Department and their employees, and the Team Physicians for medical expenses and any or all other claims.

Athlete's Signature _____

Date _____