

HAMPTON UNIVERSITY
MEDICAL HISTORY QUESTIONNAIRE

For
INTERCOLLEGIATE ATHLETICS

The contents of this form will be kept confidential by the athletic training department and will be used as supplementary information by the examining physicians and athletic trainers.

| | |
|--------------------|-----------------------------------|
| NAME _____ | SCHOOL PHONE _____ |
| BIRTH DATE _____ | SOCIAL SECURITY NUMBER _____ |
| HOME ADDRESS _____ | |
| CITY _____ | STATE _____ ZIP _____ PHONE _____ |
| SPORT _____ | |

INSTRUCTIONS: Please read all questions carefully and respond by circling the answers in the left margin. Be as specific as possible on all other responses. If an answer has changed since the previous year's response, please make the appropriate changes.

- Yes No 1. Have you ever been treated for the following in the past 12 months?
Infectious Mononucleosis _____ date _____
Viral Pneummonia _____ date _____
Other(Measles, Mumps, etc.) _____ date _____
- Yes No 2. Have you ever been treated for an asthma attack? If Yes. What brings on the attack?
What relieves the attack? _____
- Yes No 3. Do you use an inhaler when you participate in activity? If yes, what is the name of the inhaler?

- Yes No 4. Have you ever been told by a physician that you have a heart murmur? Date: _____
- Yes No 5. Have you ever been held from competition for a heart murmur? Date: _____
- Yes No 6. Have you had any tests done for a heart murmur? Date: _____
If yes, list these tests: _____
- Yes No 7. Have you ever been treated for any other heart conditions? If yes, give details: _____

- Yes No 8. Has anyone in your family been diagnosed as having any of the following?(Check if yes)
Marfans Syndrome _____
Hypertrophic Cardiomyopathy(Enlarged heart) _____
Unusual heart rhythms _____
- Yes No 9. Have you ever experienced chest pains while exercising? If yes, give details: _____

- Yes No 10. Have you ever experienced any shortness of breath or unusual fatigue associated with exercise?
If yes, give details: _____
- Yes No 11. Have you ever experienced dizziness while exercising? If yes, give details: _____

- Yes No 12. Have you had any fainting incidents while exercising? If yes, give details: _____

- Yes No 13. Have you experienced an epileptic seizure or been informed that you might have epilepsy?

- Yes No 14. If answer to question 13 is yes, are your seizures controlled by medication? Name of medication _____
- Yes No 15. Have you had hepatitis during the past three years? If yes give details: _____
- Yes No 16. Have you ever taken medication to regulate your blood pressure? If yes, name of medication: _____
- Yes No 17. Do you have a family history of high blood pressure?
- Yes No 18. Have you ever been treated for diabetes?
- Yes No 19. If the answer to 18 is yes, how is it regulated: Injection type: _____
 Times/day: _____ Exercise: _____ Diet: _____
- Yes No 20. Have you ever been informed by a physician that you have sickle cell anemia or trait?
- Yes No 21. Have you had any illness requiring bed rest of one week or longer in the past year? If yes, Give details: _____

HEAD AND NECK

- Yes No 22. Have you ever been knocked out or experienced a concussion within the last 3 years?
 If yes, give details: _____
- Yes No 23. If the answer to 22 is yes, have you suffered a concussion more than once? How many? _____
- Yes No 24. Have you ever experienced seizures as the result of a head injury? If yes, give details: _____
- Yes No 25. Have you ever had any of the following? Please check and give date.
 Strained neck _____ Date _____
 Sprained neck _____ Date _____
 Fractured neck _____ Date _____
 Pinched Nerve _____ Date _____
 Whiplash _____ Date _____
 Severe headaches _____ Date _____
 If the answer to any of the above is yes, please give details: _____

EYES AND DENTAL

- Yes No 26. Do you have vision in both eyes? If no, give details: _____
- Yes No 27. Have you ever experienced temporary loss of vision? Give date: _____
 Give details: _____
- Yes No 28. Do you wear glasses during practice or competition?
- Yes No 29. Do you wear contacts during practice or competition?
- Yes No 30. Do you wear any of the following dental appliances?
 ___ Permanent bridge
 ___ Permanent crown
 ___ Braces
 ___ other Please list: _____

- Yes No 31. Do you have any dead teeth? If yes, indicate approximate location: _____
 Yes No 32. Have you ever been told that you have Temporal Mandibular Joint Syndrome(TMJ)?
 If yes, give details: _____

SHOULDER

- Yes No 33. Have you had any of the following shoulder or throwing arm injuries during the past three years
 That incapacitated you? If yes, check the appropriate side and give dates.
 Dislocation R L Date: _____
 Subluxation R L Date: _____
 Rotator Cuff Strain R L Date: _____
 Muscular Strain R L Date: _____
 Biceps tendinitis R L Date: _____
 Bursitis R L Date: _____
 AC separation R L Date: _____
 Instability R L Date: _____
- Yes No 34. Have you ever been advised to have surgery to correct a shoulder condition? Details: _____

- Yes No 35. If 34 is yes, has this surgery been performed? Details: _____
 _____ Date: _____

ELBOW AND HAND

- Yes No 36. Have you ever experienced any of the following elbow injuries during the past three years that
 Incapacitated you? If yes, check appropriate side and give date.
 Severe sprain R L Date: _____
 Severe strain R L Date: _____
 Hyperextension R L Date: _____
 Dislocation R L Date: _____
 Fracture R L Date: _____
 Tennis Elbow R L Date: _____
 Other: _____
- Yes No 37. Have you had any surgery on your elbow in the past 3 years? If yes, date: _____
 Details: _____
- Yes No 38. Have you experienced a wrist or hand injury during the past 3 years that incapacitated you? If
 Yes, check the appropriate side and give dates.
 Muscular straine R L Date: _____
 Sprain R L Date: _____
 Scaphoid fracture R L Date: _____
 Colles Fracture R L Date: _____
 Finger R L Date: _____
 Other _____ Date: _____
 Wrist dislocation R L Date: _____
 Finger dislocation R L Date: _____

Yes No 39. Have you had surgery on the forearm, wrist or hand in the past three years? If yes, give details:

BACK

Yes No 40. Have you ever had an injury to your back? Please check and give date.

Muscular strain _____ Date _____

Lumbosacral sprain _____ Date _____

Sacroiliac sprain _____ Date _____

Sciatic nerve injury _____ Date _____

Disc Injury _____ Date _____

Sponylolysis _____ Date _____

Sponylolisthesis _____ Date _____

Yes No 41. Have you had any surgery performed on your back? If yes, for what condition? _____

Yes No 42. Are you currently experiencing any back pain? If yes, what brings this pain on? _____

How long does the pain last? _____

What relieves this pain? _____

How often do you experience this pain? _____

KNEE

Yes No 43. Have you ever been told that you injured the ligaments in either knee? If yes, please check the appropriate side and give dates.

Medial side R L Date: _____

Lateral side R L Date: _____

ACL/PCL R L Date: _____

Yes No 44. Have you ever been told that you injured the meniscus(cartilage) in either knee? If yes, check the appropriate side and give dates.

Medial meniscus R L Date: _____

Lateral Meniscus R L Date: _____

Yes No 45. Have you ever experienced pain and/or popping behind your kneecap. Indicate which knee.
 R L

Yes No 46. Have you ever been advised to have surgery on a knee to correct a condition? If yes, which knee and what condition?

 R L Condition: _____

Yes No 47. If 46 is yes, has this surgery been performed? Date: _____

Yes No 48. Do you currently have knee pain? If yes, indicate which knee and give details.

 R L Details: _____

FOOT, ANKLE AND LOWER LEG

- Yes No 49. Have you ever experienced a foot, ankle, or lower leg injury during the past three years that Incapacitated you? If yes, check the appropriate side and give date.
- Sprain R L Date: _____
- Dislocation R L Date: _____
- Fracture R L Date: _____
- Stress fracture R L Date: _____ Where? _____
- Plantar fasciitis R L Date: _____
- Chronic shin splints R L
- Other _____
- Yes No 50. Do you currently have any unhealed injuries anywhere in the body? If so, give details:
- _____

GENERAL

- Yes No 51. Do you have a pin, screw, or plate anywhere in your body as a result of bone or joint surgery? If yes, please indicate body part and date of surgery.
- Body part: _____ Date of surgery: _____
- Yes No 52. Have you ever been treated for kidney stones or had a kidney injury? Give details:
- _____
- Yes No 53. Have you ever had blood in your urine? Give details:
- _____
- Yes No 54. Are you missing a paired organ(kidney, eye, testicle, etc.)? Give details:
- _____
- Yes No 55. Have you ever been told you had a hernia? Give details: Date: _____
- Body Location: _____
- Has surgery been performed? _____ Date: _____
- Yes No 56. Are you currently taking any prescription medication on a permanent or semi-permanent basis? If yes, please list the drug and the condition for which it was prescribed.
- Drug: _____ Condition: _____
- Yes No 57. Are you allergic to any medication? Please list: _____
- Yes No 58. Are you allergic to insect bites? Specify insect: _____
- What happens when you are bitten? _____
- Yes No 59. Do you have any other allergies? Please list: _____
- Yes No 60. Do you have any hearing loss in either ear? If yes, give details: _____
- Yes No 61. Has your weight fluctuated 20 pounds or more in the last year? If yes, give details: _____
- Yes No 62. Have you ever been told by a physician not to participate in competitive athletics for any medical Reason? If yes, what was that reason? _____