

# UNIVERSITY OF WISCONSIN-OSHKOSH SPORTS MEDICINE

## Incoming Student-Athlete Health History Questionnaire Form



The information contained in this medical history form will only be used by the athletic training staff of the University of Wisconsin Oshkosh for purposes of determining if you pose a health threat/risk to yourself on the athletic field. This information will remain **CONFIDENTIAL** at all times.

(PLEASE PRINT CLEARLY IN BLUE OR BLACK INK ONLY)

Name \_\_\_\_\_ Date \_\_\_\_\_  Male  Female

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Race  Caucasian  Afro-American  Hispanic  Asian/Pacific  Alaskan/Indian  Other \_\_\_\_\_

Sport(s) \_\_\_\_\_ Position(s) \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_  Right Handed  Left Handed

### **PERMANENT ADDRESS**

Street \_\_\_\_\_ Apt. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Cellular Phone \_\_\_\_\_

### **PARENT INFORMATION**

Father's Name \_\_\_\_\_ Age \_\_\_\_\_

If Deceased, Cause of Death \_\_\_\_\_ Age at Death \_\_\_\_\_

Father's Occupation \_\_\_\_\_

Address (if different from permanent address):

Street \_\_\_\_\_ Apt. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Age \_\_\_\_\_

If Deceased, Cause of Death \_\_\_\_\_ Age at Death \_\_\_\_\_

Mother's Occupation \_\_\_\_\_

Address (if different from permanent address):

Street \_\_\_\_\_ Apt. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## GENERAL MEDICAL HISTORY

### CARDIOVASCULAR FACTORS

Have you ever been told that you have a heart murmur?  YES  NO

- Please describe \_\_\_\_\_

Has a physician ever restricted your participation in sports due to any heart problems?  YES  NO

- Please describe \_\_\_\_\_

Have you ever had chest pain and/or shortness of breath during or after exercise/practice?  YES  NO

- Please describe \_\_\_\_\_

Have you ever had the feeling of your heart racing or skipping beats during or after exercise?  YES  NO

- Please describe \_\_\_\_\_

Do you get tired more quickly than your teammates/friends do during exercise/practice?  YES  NO

- Please describe \_\_\_\_\_

Have you ever felt dizzy, lightheaded, and/or passed out during or after exercise/practice?  YES  NO

- Please describe \_\_\_\_\_

Have you ever had an electrocardiogram (EKG) of your heart?  YES  NO

- Please describe \_\_\_\_\_

Have you ever been told that you have/had high blood pressure?  YES  NO

- Please describe \_\_\_\_\_

Have you ever been told that you have/had high blood cholesterol?  YES  NO

- Please describe \_\_\_\_\_

Have you had any close relatives die before age 50 of a heart problem?  YES  NO

- Please describe \_\_\_\_\_

Do any of your close relatives under the age of 50 have any heart conditions?  YES  NO

- Please describe \_\_\_\_\_

Does anyone of your family have heart rhythm problems or heart muscle disease?  YES  NO

- Please describe \_\_\_\_\_

### ALLERGIES

Have you ever been diagnosed with any allergies?  YES  NO

- Please describe \_\_\_\_\_

Are you presently taking/Have you previously taken any allergy medications?  YES  NO

- Please describe \_\_\_\_\_

Are you allergic to and/or ever had an unfavorable/allergic reaction to any medications?  YES  NO

- Please describe \_\_\_\_\_

Are you allergic to and/or ever had an unfavorable/allergic reaction to any food items?  YES  NO

- Please describe \_\_\_\_\_

Are you allergic to and/or ever had an unfavorable/allergic reaction to insect stings?  YES  NO

- Please describe \_\_\_\_\_

**ASTHMA**

Have you ever been diagnosed with asthma and/or exercised-induced asthma?  YES  NO

- Date(s) \_\_\_\_\_
- Please describe \_\_\_\_\_

Are you presently taking / have you previously taken any allergy medications / use an inhaler?  YES  NO

- Date(s) \_\_\_\_\_
- Please describe \_\_\_\_\_

How many acute asthma attacks have you had in the past 24 months? \_\_\_\_\_

- Date(s) \_\_\_\_\_
- Please describe \_\_\_\_\_

**DIABETIC HISTORY**

Have you ever been diagnosed with diabetes?  YES  NO

- Date(s) \_\_\_\_\_

Are you presently taking or have you taken any diabetic medications?  YES  NO

Medication	Form	Dosage	Frequency
_____	_____	_____	_____
_____	_____	_____	_____

Do you daily monitor your blood sugar level?  YES  NO

- Please describe \_\_\_\_\_

Please list any precautions that you take and/ or additional information not mentioned above:

\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL TESTING**

Have you ever contracted any type of hepatitis?  YES  NO

- Date(s) \_\_\_\_\_ Treatment(s) \_\_\_\_\_

Have you ever been tested for Sickle Cell Anemia, that you are aware of?  YES  NO

- Date \_\_\_\_\_ Result \_\_\_\_\_

**EYES**

Do you routinely wear prescription glasses?  YES  NO

Do you routinely wear contact lenses?  YES  NO

- What type? \_\_\_\_\_

Do you require any special devices/equipment?  YES  NO

- Please describe \_\_\_\_\_

**HEAT-RELATED PROBLEMS**

Have you ever experienced (check all that apply):

- Heat Cramps                      Date(s) \_\_\_\_\_
- Heat Exhaustion                      Date(s) \_\_\_\_\_
- Heat Stroke                      Date(s) \_\_\_\_\_

Have you ever received intravenous fluids (IV) for a heat related problem?                       YES    NO

- Date(s) \_\_\_\_\_

Have you ever been hospitalized for a heat related problem?                       YES    NO

- Date(s) \_\_\_\_\_ Where? \_\_\_\_\_

**PRESCRIPTION MEDICATIONS/ HERBS/ SUPPLEMENTS**

Please list ALL prescription & over-the-counter medications, herbs and supplements that you are CURRENTLY taking or have taken regularly in the past, and for what purpose:

MEDICATIONS	PURPOSE	DOSAGE	DATE(S)

**HEAD INJURIES/ CONCUSSIONS**

History of Head Injury / Concussion Injury?                       YES    NO

- List Dates/Time Missed \_\_\_\_\_
- Please Describe Injury \_\_\_\_\_

Were Any Diagnostic Tests Performed? (Check all that apply)                       YES    NO

- MRI    CT-Scan    X-Rays    Neuropsychological Testing    Other \_\_\_\_\_

Have you ever been hospitalized, knocked out, become unconscious, and/or lost your memory due to a head injury/concussion?                       YES    NO

- Please describe \_\_\_\_\_

Do you suffer from headaches?                       YES    NO

- How often?    Every Day    1-2 times/week    1-2 times/month
- Where are your headaches located?    Left side of head    Right side of head  
 Front of head    Back of head    All over your head

Do you have a history of migraine headaches?                       YES    NO

- How often? \_\_\_\_\_ Please describe \_\_\_\_\_
- Medications taken for migraines? \_\_\_\_\_

Have you had headaches for more than three (3) months?                       YES    NO

- If yes, please explain \_\_\_\_\_

## ORTHOPAEDIC HISTORY

### CERVICAL SPINE/ NECK

History of Cervical Spine / Neck Injury?  YES  NO

- List Dates/Time Missed \_\_\_\_\_
- Please Describe Injury \_\_\_\_\_

Were Any Diagnostic Tests Performed? (Check all that apply)  YES  NO  
 MRI  CT-Scan  X-Rays  Bone Scan  Other \_\_\_\_\_

Have you ever been hospitalized for a Cervical Spine / Neck injury?  YES  NO

- When? \_\_\_\_\_ Where? \_\_\_\_\_
- Please describe \_\_\_\_\_

Have you ever had "burners", "stingers", or any brachial plexus injury?  YES  NO

- How many? \_\_\_\_\_ Date(s)/Time missed? \_\_\_\_\_

Have you ever had surgery of any kind on your Cervical Spine / Neck?  YES  NO

- When? \_\_\_\_\_ Surgeon? \_\_\_\_\_
- Please describe \_\_\_\_\_

Do you presently wear a neck roll or neck collar (football specific)?  YES  NO

Do you presently wear a "Cowboy Collar" or helmet restrictor plate?  YES  NO

Have you ever worn or been advised to wear a neck roll, neck collar, "Cowboy Collar", and/or Helmet restrictor plate?  YES  NO

If yes, please explain \_\_\_\_\_

### SHOULDER / UPPER ARM

History of Shoulder / Upper Arm injury?  YES  NO

- List Dates/Times missed \_\_\_\_\_
- Please describe \_\_\_\_\_

Were Any Diagnostic Tests Performed? (Check all that apply)  YES  NO  
 MRI  CT-Scan  X-Rays  Bone Scan  Other \_\_\_\_\_

Have you ever been hospitalized for a Shoulder / Upper Arm injury?  YES  NO

- When? \_\_\_\_\_ Where? \_\_\_\_\_
- Please describe \_\_\_\_\_

Have you ever had surgery of any kind on your Shoulder / Upper Arm injury?  YES  NO

- When? \_\_\_\_\_ Surgeon? \_\_\_\_\_
- Please describe \_\_\_\_\_

Have you ever experienced numbness and/or tingling in your arms/fingers?  YES  NO

- Dates \_\_\_\_\_
- Please describe \_\_\_\_\_

**ELBOW / FOREARM**

History of Elbow / Forearm injury?  YES  NO

- List Dates/Times missed \_\_\_\_\_
- Please describe \_\_\_\_\_

Were Any Diagnostic Tests Performed? (Check all that apply)  YES  NO

- MRI  CT-Scan  X-Rays  Bone Scan  Other \_\_\_\_\_

Have you ever been hospitalized for a Elbow / Forearm injury?  YES  NO

- When? \_\_\_\_\_ Where? \_\_\_\_\_
- Please describe \_\_\_\_\_

Have you ever had surgery of any kind on your Elbow / Forearm?  YES  NO

- When? \_\_\_\_\_ Surgeon? \_\_\_\_\_
- Please describe \_\_\_\_\_

**WRIST, HAND, & FINGERS**

History of Wrist, Hand, and/or Finger injury?  YES  NO

- List Dates/Times missed \_\_\_\_\_
- Please describe \_\_\_\_\_

Were Any Diagnostic Tests Performed? (Check all that apply)  YES  NO

- MRI  CT-Scan  X-Rays  Bone Scan  Other \_\_\_\_\_

Have you ever been hospitalized for a Wrist, Hand, and/or Finger injury?  YES  NO

- When? \_\_\_\_\_ Where? \_\_\_\_\_
- Please describe \_\_\_\_\_

Have you ever had surgery of any kind on your Wrist, Hand, and/or Finger(s)?  YES  NO

- When? \_\_\_\_\_ Surgeon? \_\_\_\_\_
- Please describe \_\_\_\_\_

**RIBS / THORAX / CHEST**

History of Ribs / Thorax / Chest injury?  YES  NO

- List Dates/Times missed \_\_\_\_\_
- Please describe \_\_\_\_\_

Were Any Diagnostic Tests Performed? (Check all that apply)  YES  NO

- MRI  CT-Scan  X-Rays  Bone Scan  Other \_\_\_\_\_

Have you ever been hospitalized for a Ribs / Thorax / Chest injury?  YES  NO

- When? \_\_\_\_\_ Where? \_\_\_\_\_
- Please describe \_\_\_\_\_

## **SPINE / LOW BACK / SACROILIAC JOINT**

History of Spine / Low Back / Sacroiliac joint injury?  YES  NO

- List Dates/Times missed \_\_\_\_\_
- Please describe \_\_\_\_\_

Were Any Diagnostic Tests Performed? (Check all that apply)  YES  NO

MRI  CT-Scan  X-Rays  Bone Scan  Other \_\_\_\_\_

Have you ever been hospitalized for a Spine / Low Back / Sacroiliac joint injury?  YES  NO

- When? \_\_\_\_\_ Where? \_\_\_\_\_
- Please describe \_\_\_\_\_

Have you ever had surgery of any kind on your Spin / Low Back / Sacroiliac joint?  YES  NO

- When? \_\_\_\_\_ Surgeon? \_\_\_\_\_
- Please describe \_\_\_\_\_

Have you ever experienced numbness and/or down one (1) or both legs?  YES  NO

- Dates \_\_\_\_\_
- Please describe \_\_\_\_\_

## **HIP / GROIN**

History of Hip / Groin injury?  YES  NO

- List Dates/Times missed \_\_\_\_\_
- Please describe \_\_\_\_\_

Were Any Diagnostic Tests Performed? (Check all that apply)  YES  NO

MRI  CT-Scan  X-Rays  Bone Scan  Other \_\_\_\_\_

Have you ever been hospitalized for a hip or groin injury?  YES  NO

- When? \_\_\_\_\_ Where? \_\_\_\_\_
- Please describe \_\_\_\_\_

## **THIGH (including quadriceps & hamstrings)**

History of Thigh injury?  YES  NO

- List Dates/Times missed \_\_\_\_\_
- Please describe \_\_\_\_\_

Were Any Diagnostic Tests Performed? (Check all that apply)  YES  NO

MRI  CT-Scan  X-Rays  Bone Scan  Other \_\_\_\_\_

Have you ever been hospitalized for a Thigh injury?  YES  NO

- When? \_\_\_\_\_ Where? \_\_\_\_\_
- Please describe \_\_\_\_\_

Have you ever had surgery of any kind for a Thigh injury?  YES  NO

- When? \_\_\_\_\_ Surgeon? \_\_\_\_\_
- Please describe \_\_\_\_\_

**KNEE**

History of Knee injury?  YES  NO

- List Dates/Times missed \_\_\_\_\_
- Please describe \_\_\_\_\_

Were Any Diagnostic Tests Performed? (Check all that apply)  YES  NO

- MRI  CT-Scan  X-Rays  Bone Scan  Other \_\_\_\_\_

Have you ever been hospitalized for a Knee injury?  YES  NO

- When? \_\_\_\_\_ Where? \_\_\_\_\_
- Please describe \_\_\_\_\_

Have you ever had surgery of any kind for a Knee injury?  YES  NO

- When? \_\_\_\_\_ Surgeon? \_\_\_\_\_
- Please describe \_\_\_\_\_

Have you ever/Do you presently wear a knee brace?  YES  NO

- Which knee? \_\_\_\_\_ Brand/Model? \_\_\_\_\_
- Reason for wearing \_\_\_\_\_

**ANKLE / LOWER LEG**

History of Ankle / Lower leg injury?  YES  NO

- List Dates/Times missed \_\_\_\_\_
- Please describe \_\_\_\_\_

Were Any Diagnostic Tests Performed? (Check all that apply)  YES  NO

- MRI  CT-Scan  X-Rays  Bone Scan  Other \_\_\_\_\_

Have you ever been hospitalized for an Ankle / Lower leg injury?  YES  NO

- When? \_\_\_\_\_ Where? \_\_\_\_\_
- Please describe \_\_\_\_\_

Have you ever had surgery of any kind for an Ankle / Lower leg injury?  YES  NO

- When? \_\_\_\_\_ Surgeon? \_\_\_\_\_
- Please describe \_\_\_\_\_

Do you presently  Tape your Ankle(s)  Use ankle braces  Other \_\_\_\_\_

- Please describe \_\_\_\_\_

**FOOT / TOE(S)**

History of Foot ? Toe(s) injury?  YES  NO

- List Dates/Times missed \_\_\_\_\_
- Please describe \_\_\_\_\_

Were Any Diagnostic Tests Performed? (Check all that apply)  YES  NO

- MRI  CT-Scan  X-Rays  Bone Scan  Other \_\_\_\_\_

Have you ever had surgery of any kind for a Foot / Toe injury?  YES  NO

- When? \_\_\_\_\_ Surgeon? \_\_\_\_\_
- Please describe \_\_\_\_\_

**PLEASE ANSWER (All questions are strictly CONFIDENTIAL & will not be shared with parents/coaches)**

- YES  NO Have you ever had any injury or illness other than those already noted?
- YES  NO Do you have any ongoing or chronic illnesses?
- YES  NO Have you ever been hospitalized overnight?
- YES  NO Have you ever been told by a physician to restrict your sports activity or not to participate in sports?
- YES  NO Are you currently under a physician's care for any medical conditions?
- YES  NO Have you ever been under the care of a psychiatrist and/or psychologist?
- YES  NO Have you consulted and/or been under the care of a chiropractor, hypnotist, acupuncturist, massage therapist, spiritual healer, and/or other such practitioner in the past five (5) years?
- YES  NO Do you take any vitamin supplements?
- YES  NO Have you ever had a rash or hives develop during and/or after activity?
- YES  NO Do you have any skin problems? (itching, rashes, acne, herpes, eczema, warts, fungus, or blisters)
- YES  NO Do you cough, wheeze, or have trouble breathing during or after exercise/practice?
- YES  NO Do you have only one of two paired, functioning organs (kidney, ovary, testicle, eye)?
- YES  NO Have you ever been told that you have kidney disease?
- YES  NO Have you had a viral infection (i.e. mononucleosis, myocarditis, etc.) within the past six (6) months?
- YES  NO Have you ever had seizures or convulsions?
- YES  NO Do you have ringing in your ears or trouble hearing?
- YES  NO Do you have frequent ear infections or nosebleeds?
- YES  NO Do you require any special equipment (braces, neck rolls, dental, orthotics, hearing aids, etc)?
- YES  NO Have you ever had the chickenpox? If yes, when? \_\_\_\_\_
- YES  NO Does anyone in your family have sickle cell trait or disease?
- YES  NO Have you ever been tested for sickle cell trait or disease? If yes, when? \_\_\_\_\_
- YES  NO Do you have any body piercing or tattoos?
- YES  NO Are you aware of any reasons why you should not participate in intercollegiate athletics at UW-Oshkosh at this time?
- YES  NO Have you had a tetanus booster within the past five (5) years? If yes, when? \_\_\_\_\_
- YES  NO Have you ever received the Hepatitis B (HBV) vaccination series (all 3 shots)? If yes, when? \_\_\_\_\_
- YES  NO Do you smoke cigarettes, use smokeless tobacco, or use tobacco in any form?
- YES  NO Do you use alcohol? If yes, how often? \_\_\_\_\_
- YES  NO Have you ever used / tried marijuana, cocaine, or any other illicit "street" drug?
- YES  NO Do you have any questions regarding drugs, tobacco, or alcohol?
- YES  NO Do you feel stressed out?
- YES  NO If yes to the previous question, do you feel as though you get the necessary support to deal with your stress?
- YES  NO Have you had a weight change (loss or gain) of greater than 10 pounds in the last year?
- YES  NO Are you a vegetarian? If yes, what type? \_\_\_\_\_
- YES  NO Do you regularly lose weight to participate in your sport?
- YES  NO Do you want to weigh more or less than you presently do?
- YES  NO Have you ever felt forced to limit your food intake due to concerns about your weight and/or body size?
- YES  NO Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorder?
- YES  NO Would you like to meet with a dietician to discuss your nutritional needs or eating habits?
- YES  NO Do you currently have any dental issues (abscesses, crowns, or false teeth)?

**Female Athletes ONLY**

- YES  NO When was your first menstrual period (mm/yyyy)? \_\_\_\_\_
- YES  NO Are your menstrual periods regular on a monthly basis?
- YES  NO ▪ What is the date of your most recent menstrual period? \_\_\_\_\_
- YES  NO Do you have painful menstrual periods?
- YES  NO Do you take medications for painful menstrual periods? If so, what? \_\_\_\_\_
- YES  NO Do you do a regular breast self exam?
- YES  NO Do you get an annual pelvic/ pap exam? Date of last exam: \_\_\_\_\_

**Male Athletes ONLY**

- YES  NO Have you ever had any testicular infection or injury?
- YES  NO Do you do a regular testicular self exam?



I, the undersigned, hereby acknowledge, affirm, and represent that all statements on pages on (1) through eleven (11) are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I fully understand that the University of Wisconsin Oshkosh, its agents, servants, trustees, and employees disclaim liability, and will not be held liable for any injuries and/or illnesses not noted.

\_\_\_\_\_  
Student-Athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student-Athlete Print Name

\_\_\_\_\_  
Parent/Guardian Signature (*if under 18 years of age*)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Print Name

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**Reviewed By:** (Please have your physician review this document with you and sign below)

Physician:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

Athletic Trainer:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

Team Physician:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name