

**Bellarmino University**  
**Department of Intercollegiate Athletics**  
**Student-Athlete Health History Questionnaire Form**

The information contained in this medical history form will only be used by the Bellarmine University Sports Medicine Staff for purposes of determining if you pose a health threat/risk to yourself on the athletic field. Return this form (completed) to the Athletic Trainers office. This information will remain confidential at all times.

**Please print clearly in BLUE or BLACK INK only! Pencil is NOT acceptable. Initial any changes.**

**A. General Information**

Name (Full Legal) \_\_\_\_\_ Date \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sport(s) \_\_\_\_\_

**PERMANENT ADDRESS:**

\_\_\_\_\_ STREET \_\_\_\_\_

\_\_\_\_\_ CITY STATE ZIP CODE \_\_\_\_\_

Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Cellular Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

**B. Family Health History**

Father's health conditions: \_\_\_\_\_ Age: \_\_\_\_\_ If deceased, cause of death \_\_\_\_\_ Age: \_\_\_\_\_

Mother's health conditions: \_\_\_\_\_ Age: \_\_\_\_\_ If deceased, cause of death \_\_\_\_\_ Age: \_\_\_\_\_

Sibling's health conditions: \_\_\_\_\_ Age: \_\_\_\_\_ If deceased, cause of death \_\_\_\_\_ Age: \_\_\_\_\_

Sibling's health conditions: \_\_\_\_\_ Age: \_\_\_\_\_ If deceased, cause of death \_\_\_\_\_ Age: \_\_\_\_\_

Sibling's health conditions: \_\_\_\_\_ Age: \_\_\_\_\_ If deceased, cause of death \_\_\_\_\_ Age: \_\_\_\_\_

Paternal Grand Parents Health: \_\_\_\_\_ if deceased, cause of death \_\_\_\_\_ Age: \_\_\_\_\_

Maternal Grand Parents Health: \_\_\_\_\_ if deceased, cause of death \_\_\_\_\_ Age: \_\_\_\_\_

**C. Medical Questions**

If you have answered **YES** to any of the following questions that does not have a space to clarify the answer, you will need to provide an explanation at the in the space provided on page 3 or on a separate sheet of paper.

**All answers to the questions will remain confidential.**

1. Have you ever had chest pain and/or shortness of breath, dizziness, lightheadedness, or passed out during or after exercise/practice?  YES  NO  
If yes, what was the cause? \_\_\_\_\_
2. Have you ever had the feeling of your heart racing or skipping beats during or after exercise/practice?  YES  NO
3. Do you get tired more quickly than your teammates/friends do during exercise/practice?  YES  NO
4. Have you ever been told that you have a heart murmur?  YES  NO
5. Has any family member or close relative had heart problems and/or died of sudden death before the age of 50?  YES  NO
6. Has a physician ever denied or restricted your participation in sports due to any heart/cardiovascular problems?  YES  NO
7. Have you ever had an electrocardiogram (EKG) and/or echocardiogram (ECHO) of your heart?  YES  NO  
If yes, what were the reason and the result? \_\_\_\_\_
8. Does anyone in your family have a history of high blood pressure or high cholesterol?  YES  NO
9. Have you ever been diagnosed with seasonal allergies?  YES  NO
10. Are you presently taking or have you previously taken any allergy medications?  YES  NO
11. Are you allergic to and/or ever had an unfavorable/allergic reaction to any medications, food, insect bites, or bee stings?  YES  NO  
a. If YES, what are you allergic to? \_\_\_\_\_
12. Have you ever been diagnosed with asthma and/or exercised-induced asthma?  YES  NO
13. Are you presently taking or have you previously taken any asthma medications or used an inhaler?  YES  NO  
Date(s) \_\_\_\_\_  
Please describe \_\_\_\_\_
14. If yes, then how many times do you use your rescue inhaler (e.g., Albuterol, Proventil, etc.) during an average week? \_\_\_\_\_
15. If yes, then how many acute asthma attacks have you had in the past 12 months? \_\_\_\_\_

16. Have you ever suffered a head injury/concussion (no matter how minor)?  YES  NO
17. List date(s)/time(s) (e.g., practices or games) missed \_\_\_\_\_
18. Do you suffer from headaches?  YES  NO How often?  Every Day  1-2 Times/Week  1-2 Times/Month
19. Where are your headaches located?  Left Side of Head  Right Side of Head  Front of Head  Back of Head  All Over Head
20. Do you have a history of migraine headaches?  YES  NO
21. When was your last eye exam? \_\_\_\_\_
22. Have you ever suffered an injury to your eye(s) and/or been advised that you have an eye disease?  YES  NO
23. Have you ever suffered from blurred vision, double vision, tunnel vision, and/or any other Visual disturbances?  YES  NO
24. Do you wear glasses?  YES  NO
25. Do you wear contact lenses?  YES  NO Type \_\_\_\_\_
26. Do you require any special hearing devices/equipment?  YES  NO Type \_\_\_\_\_
27. Have you ever suffered an injury to or had a problem with your ear(s), nose, and/or throat?  YES  NO
28. Have you ever suffered an injury to or had a problem with your mouth, jaw, and/or teeth?  YES  NO
29. Have you ever suffered an injury to or had a problem with your cervical spine and/or neck?  YES  NO
30. Have you ever had "burners," "stingers," or brachial plexus injuries?  YES  NO
31. Have you ever experienced numbness and/or tingling in your arms/fingers?  YES  NO
32. Have you ever suffered an injury to or had a problem with your shoulder/upper arm?  YES  NO
33. Have you ever suffered an injury to or had a problem with your elbow/forearm?  YES  NO
34. Have you ever suffered an injury to or had a problem with your wrist(s), hand(s), and/or finger(s)?  YES  NO
35. Have you ever suffered an injury to or had a problem with your spine/low back/sacroiliac joint?  YES  NO
36. Have you ever had numbness/tingling down one or both legs?  YES  NO
37. Have you ever suffered an injury to or had a problem with your hip/groin (including hernias and/or sports hernias)?  YES  NO
38. Have you ever suffered an injury to or had a problem with your thigh, hamstring, and/or quadriceps?  YES  NO
39. Have you ever suffered an injury to or had a problem with your knee and/or patella (kneecap)?  YES  NO
40. Have you ever or do you presently wear a knee brace?  YES  NO  
 Which knee? \_\_\_\_\_ Brand/Model of brace? \_\_\_\_\_  
 Reason for wearing? \_\_\_\_\_
41. Have you ever suffered an injury to or had a problem with your ankle/lower leg/feet/toes?  YES  NO
42. Do you presently  tape your ankle(s)  use ankle brace(s)  Other. Please describe \_\_\_\_\_
43. Have you ever suffered an injury to your rib/thorax/chest?  YES  NO
44. Have you ever been diagnosed with a problem with your stomach, abdomen, intestines, or rectum?  YES  NO
45. Have you ever suffered from severe or recurrent abdominal pain?  YES  NO
46. Have you ever suffered from chronic or recurrent diarrhea?  YES  NO
47. Do you have only one of two paired, functioning organs (e.g., kidney, testicles, ovary)?  YES  NO
48. Have you ever been diagnosed with a communicable disease (STD; HIV; Hepatitis A, B, or C; Herpes Simplex; Syphilis; Tuberculosis)?  YES  NO
49. Do you have any skin problems that we should be aware of (e.g., itching, rashes, acne, warts, eczema, fungus)?  YES  NO
50. Have you ever suffered from a heat-related illness?  YES  NO  
 a. (check all that apply):  heat cramps/heat syncope (fainting)-  heat exhaustion-  heat stroke-
51. Have you ever received intravenous fluids (IV) or been hospitalized for a heat-related problem?  YES  NO
52. Do you or anyone in your Family have Diabetes?  YES  NO
53. If yes, do you daily monitor your blood sugar level?  YES  NO  
 How many times per day? \_\_\_\_\_ What is your average level? \_\_\_\_\_
54. Have you had your A1C level checked within the last three (3) months?  YES  NO
55. Have you had any hypoglycemic episodes (low blood sugar) within the last twelve (12) months?  YES  NO
56. Have you ever, to the best of your knowledge, been tested for Sickle Cell Anemia?  YES  NO
57. Does any member of your family, to the best of your knowledge, carry the Sickle Cell Trait/have Sickle Cell Anemia?  YES  NO
58. Have you ever been advised that you carry the Sickle Cell Trait/have Sickle Cell Anemia?  YES  NO
59. Have you ever had any injury or illness other than those already noted?  YES  NO
60. Do you have any ongoing or chronic illnesses? If Yes, What? \_\_\_\_\_  YES  NO

- 61. Have you ever been told by a physician to restrict your sports activity or not to participate in a sport?  YES  NO
- 62. Have you ever been under the care of a psychiatrist and/or psychologist?  YES  NO
- 63. Have you ever had a rash or hives develop during and/or after exercise?  YES  NO
- 64. Have you ever been told that you have kidney disease?  YES  NO
- 65. Have you ever had Rubella (German Measles) and/or Rubeolla (Red Measles) or Chicken Pox?  YES  NO
- 66. Have you ever had a stomach and/or duodenal ulcer?  YES  NO
- 67. Have you had a viral infection (i.e., mononucleosis, myocarditis) within the past six (6) months?  YES  NO
- 68. Have you ever been diagnosed with MRSA Staff Infection or been identified as an MRSA Carrier?  YES  NO
- 69. Have you ever had seizures, convulsions, and/or epilepsy?  YES  NO
- 70. Have you ever had gallbladder disease and/or a urinary problem?  YES  NO
- 71. Do you have frequent ear infections or nosebleeds?  YES  NO
- 72. Have you had a tetanus booster within the past five (5) years? If yes, when? \_\_\_\_\_  YES  NO
- 73. Have you ever received the Hepatitis B (HBV) vaccination series (all 3 shots)? If yes, when? \_\_\_\_\_  YES  NO
- 74. Have you had a weight change (loss or gain) of greater than 10 pounds in the past year?  YES  NO
- 75. What is your ideal weight? \_\_\_\_\_
- 76. Are you a strict vegetarian, vegan, or do you have an atypical diet? If yes, what kind \_\_\_\_\_  YES  NO
- 77. Would you like information on nutrition or healthy eating habits for athletes?  YES  NO
- 78. Do you regularly lose weight to participate in your sport?  YES  NO
- 79. Do you want to weigh more or less, than you presently do?  YES  NO
- 80. Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorders?  YES  NO
- 81. Do you smoke? Regularly, Socially?  YES  NO
- 82. Do you use Tobacco Products? If Yes, what kinds? \_\_\_\_\_  YES  NO

**For Females Only**

- 83. At what age did you have your first menstrual period? \_\_\_\_\_
- 84. Have you had menstrual periods within the past 12 months?  YES  NO
  - If yes, how many? \_\_\_\_\_ When was your most recent menstrual period? \_\_\_\_\_
  - How much time do you usually have from the start of one period to the start of another? \_\_\_\_\_  YES  NO
  - What was the longest time between menstrual periods within the past year? \_\_\_\_\_
- 85. Do you have painful or heavy menstrual periods?  YES  NO
- 86. Do you take any medications during your menstrual periods? If yes, what? \_\_\_\_\_  YES  NO
- 87. Do take birth control pills? If yes, what brand? \_\_\_\_\_  YES  NO
- 88. Have you ever had any problems with your breasts?  YES  NO
- 89. Have you had a pelvic examination within the last year?  YES  NO

**For Males Only**

- 90. Have you ever had a testicular examination? Date \_\_\_\_\_  YES  NO
- 91. Have you ever been diagnosed with testicular cancer?  YES  NO

**Answers**

If you have answered yes to any of the above, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Prescription Medications:**

Please list all prescription and over-the-counter medications you are currently taking or have taken in the past two (2) years and for what purpose.

<u>MEDICATION</u>	<u>PURPOSE</u>	<u>DOSAGE</u>	<u>DATE(S)</u>

**Supplements / Ergogenic Aids:**

Please list all supplements/Ergogenic aids that you are currently taking or have taken in the past two (2) years and for what purpose.

<u>SUPPLEMENT</u>	<u>PURPOSE</u>	<u>DOSAGE</u>	<u>DATE(S)</u>

**Catastrophic Injury Statement**

The possibility of sustaining a catastrophic injury is inherent in any athletic activity. I understand that by participating in intercollegiate athletics at Bellarmine University, the potential for a catastrophic injury does exist. With this fact in mind, I understand the importance of the rules and the procedures as well as the necessity of using proper techniques. Furthermore, I understand that the possibility of a catastrophic injury does exist even though I follow all instruction as to proper technique. I understand that the team physicians will have the final authority to eliminate me from further participation due to an injury, illness, or medical condition, which could represent a risk to my safety and an undue liability risk to Bellarmine University.

Student-Athlete's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Medical History Statement**

I have completed this medical history questionnaire and answered it truthfully and to the best of my knowledge. I am prepared to answer questions from the Bellarmine University medical staff (including team physicians, athletic trainers, nurses, and consultants) concerning this medical history and medical conditions. I affirm also that I do not suffer from any disability, injury, condition, or complaint that I have **not disclosed** on this form. I further recognize the importance of fully and accurately disclosing my physical conditions, past and present, to the Bellarmine University medical staff and its Consultants as it may be a matter of life or death.

Student-Athlete's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Authorization to Treat/Authorization to Release Information**

I give authorization to the athletic training staff, team physicians, health services, and the medical consultants of Bellarmine University to evaluate and treat any injuries that may occur during my participation in intercollegiate athletics. I also give authorization to the athletic training staff to make referrals for treatment to the team physicians and/or other medical consultants of Bellarmine University. I give authorization to the athletic training staff to communicate with the physicians, health services, and medical consultants of Bellarmine University about any injuries and inform the coaching staff of my particular sport(s) and my parents as to the nature of my injury (ies), limitations, and estimated time of return. Finally, I give authorization to athletic training staff to share with the coaching staff emergency information as to my medical history (i.e., allergies, conditions, etc.) and insurance information which would be considered important for health care staff to have if I were in an accident and unable to give this information. I understand that this authorization is valid for one calendar year and that any or all of it may be revoked by me at any time by doing so in writing.

Student -Athletes Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Physician Review**

I have reviewed this health history at the time of this student-athlete's Pre-participation Physical Exam.

\_\_\_\_\_  
Physician's Name (print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Bellarmino University Sports Medicine Review**

\_\_\_\_\_  
Reviewers Name (print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewers Name (print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewers Name (print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date