UNIVERSITY OF MAINE AT FORT KENT

Athletic Training Department Student-Athlete Health History Questionnaire

The information contained in this medical history form will only be used by the Athletic Training Department of the University of Maine at Fort Kent for the purpose of determining if you pose a health risk/threat to yourself on the athletic field. This information will be kept CONFIDENTIAL at all times.

Please Print Clearly Below

Personal Information

Name _____

Address _____

Address while attending UMFK _____

Phone where you will be able to be reached during your attendance at UMFK _____

EMAIL (prefer UMaine account) _____

Parent/Guardian Information

Father/Guardian _____

Address _____

City State Zip Code _____

Home Phone _____

Work Phone _____

Mother/Guardian _____

Address _____

City State Zip Code _____

Home Phone _____

Work Phone _____

Health Insurance Information

Insurance Company _____

Insurance Address _____

Policy # _____

Group # _____

Phone _____

Name on Policy _____ Relationship to Athlete _____

Type of Insurance: ☐ PPO ☐ HMO ☐ Other _____

Primary Care Physician _____

Emergency Contact Information

Name _____

Relationship to Athlete _____

Address _____

Home Phone _____ Cell phone _____ Work Phone _____

Please Answer the following questions in BOLD by indicating either YES or NO. For certain YES answers, also answer the follow-up questions and provide an explanation in the space provided.

The information provided will remain confidential at all times.

1. Has a doctor ever denied/restricted your participation in sports for any reason? ☐ Yes ☐ No

2. Do you have an ongoing medical condition (like diabetes or asthma)? ☐ Yes ☐ No

3. Are you currently taking any prescription or non-prescription (over the counter) medicines or pills? ☐ Yes ☐ No

If you answered 'Yes' to question 3, please explain below.

Please list ALL prescription and over-the-counter medications that you are taking or have taken in the past: (Examples: Sleeping Pills, anti-histamines, anti-inflammatory, nutritional supplements)

Medication	Purpose	Dosage	How often?

4. Do you have allergies to medicines, pollens, foods, or stinging insects? ☐ Yes ☐ No

If you answered 'yes' to question 4, please answer the following questions and explain below.

a. Have you ever been diagnosed with any allergies? ☐ Yes ☐ No

Description _____

b. Are you presently or have you previously taken allergy medications? ☐ Yes ☐ No

Description _____

c. Are you allergic to and / or ever had an unfavorable /allergic reaction to any medications? ☐ Yes ☐ No

Description _____

d. Are you allergic to and/or ever had an unfavorable/allergic reaction to any food items? ☐ Yes ☐ No

Description _____

e. Are you allergic to and/or ever had an unfavorable /allergic reaction to bee stings, insect bites, etc.? ☐ Yes ☐ No

Description _____

5. Have you ever passed out or nearly passed out DURING exercise? ☐ Yes ☐ No

6. Have you ever passed out or nearly passed out AFTER exercise? ☐ Yes ☐ No

7. Have you ever had discomfort/pain/or pressure in your chest during exercise? ☐ Yes ☐ No

8. Does your heart race or skip beats during exercise? ☐ Yes ☐ No

9. Has a doctor ever told you that you have: (check all the apply)

☐ High blood pressure ☐ Heart Murmur

☐ High Cholesterol ☐ Heart infection

10. Has a doctor ever ordered a test for your heart (ECG/electrocardiogram/etc.)? ☐ Yes ☐ No

If you answered 'yes' to any of the questions 5-10, please answer the following questions and explain below.

a. Have you ever had chest pain and/or shortness of breath during/after exercise or practice? ☐ Yes ☐ No

Description _____

b. Have you ever felt dizzy, lightheaded, and / or passed out during or after exercise/practice? ☐ Yes ☐ No

Description _____

c. Have you ever had the feeling of your heart racing or skipping beats during or after exercise/ practice? ☐ Yes ☐ No

Description _____

d. Do you get tired more quickly than your teammates/friends do during exercise/ practice? ☐ Yes ☐ No

Description _____

e. Have you ever been told you have a heart murmur? ☐ Yes ☐ No

Description _____

f. Has any family member or relative died of heart problems and/or of sudden death before age 35? ☐ Yes ☐ No

g. Has a physician ever denied or restricted your participation in sports due to any heart problems? ☐ Yes ☐ No

Description _____

h. Have you ever had an electrocardiogram (EKG) of your heart? ☐ Yes ☐ No

Description _____

i. Have you ever been told that you have/had high blood pressure? ☐ Yes ☐ No

Description _____

j. Have you ever been told that you have/had high cholesterol? ☐ Yes ☐ No

Description _____

11. Has anyone in your family died for no apparent reason? ☐ Yes ☐ No

12. Does anyone in your family have a heart problem? ☐ Yes ☐ No

13. Has any family member or relative died of heart problems or of sudden death before age 50? ☐ Yes ☐ No

14. Does anyone in your family have Marfan syndrome? ☐ Yes ☐ No

15. Have you ever spent the night in the hospital? ☐ Yes ☐ No

16. Have you ever had surgery? ☐ Yes ☐ No

17. Have you ever had in injury - like a sprain, muscle or ligament tear, or tendonitis- that caused you to miss a practice or game? ☐ Yes ☐ No

18. Have you ever had broken bones or fractured bones, or dislocated joints? ☐ Yes ☐ No

19. Have you had a bone or joint injury that required an X-ray, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? ☐ Yes ☐ No

20. Have you ever had a stress fracture? ☐ Yes ☐ No

21. Have you been told that you have or have had an X- ray for atlanto-axial (neck) instability? ☐ Yes ☐ No

If you answered 'yes' to question 21, please answer the following questions and explain below.

Description _____

List dates/times missed _____

Were any diagnostic tests performed? ☐ Yes ☐ No (Check all that apply):

☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ X-ray ☐ Other _____

Have you ever been hospitalized for a cervical spine/neck injury? ☐ Yes ☐ No

When _____ Where _____

Description

Have you ever had "Burners", "Stingers", or any Brachial Plexus Injury? ☐ Yes ☐ No

How many? _____ Dates/Times missed _____

Have you ever had surgery of any kind on your cervical spine / neck? ☐ Yes ☐ No

When _____ Surgeon _____

Description _____

22. Do you regularly use a brace or assistive device? ☐ Yes ☐ No

23. Do you require taping? ☐ Yes ☐ No

If you answered 'yes' to any of questions 18-20 and or/ 22/23, please answer the following questions and explain below.

Shoulder/ Upper Arm

Do you have a history of shoulder/ upper arm injuries? ☐ Yes ☐ No

List dates/times missed _____

Description _____

Were any diagnostic tests performed? ☐ Yes ☐ No (Check all that apply):

☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ X-ray ☐ Other _____

Have you ever been hospitalized for a shoulder/upper arm injury? ☐ Yes ☐ No

When? _____ Where? _____

Description _____

Have you ever had surgery of any kind on your shoulder/ upper arm? ☐ Yes ☐ No

When? _____ Surgeon? _____

Description _____

Have you ever experienced numbness and/ or tingling in your arms? ☐ Yes ☐ No

When? _____

Description _____

Elbow / Forearm

Do you have a history of elbow/ forearm injuries? ☐ Yes ☐ No

List dates/times missed _____

Description _____

Were any diagnostic tests performed? ☐ Yes ☐ No (Check all that apply):

☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ X-ray ☐ Other _____

Have you ever been hospitalized for an elbow/forearm injury? ☐ Yes ☐ No

When? _____ Where? _____

Description _____

Have you ever had surgery of any kind on your elbow/forearm? ☐ Yes ☐ No

When? _____ Surgeon? _____

Description _____

Wrist/ Hand/ Fingers

Do you have a history of wrist, hand, and /or finger injuries? ☐ Yes ☐ No

List dates/times missed _____

Description _____

Were any diagnostic tests performed? ☐ Yes ☐ No (Check all that apply):

☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ X-ray ☐ Other _____

Have you ever been hospitalized for a wrist, hand, and/ or finger injury? ☐ Yes ☐ No

When? _____ Where? _____

Description _____

Have you ever had surgery of any kind on your wrist, hand, and / or finger (s)? ☐ Yes ☐ No

When? _____ Surgeon? _____

Description _____

Spine/ Low Back/ Sacroiliac Joint

Do you have a history of spine/ low back/ sacroiliac joint injuries? ☐ Yes ☐ No

List dates/times missed _____

Description _____

Were any diagnostic tests performed? ☐ Yes ☐ No (Check all that apply):

☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ X-ray ☐ Other _____

Have you ever been hospitalized for a spine/low back/ sacroiliac joint injuries? ☐ Yes ☐ No

When? _____ Where? _____

Description _____

Have you ever had surgery of any kind on your spine/low back/ sacroiliac joint? ☐ Yes ☐ No

When? _____ Surgeon? _____

Description _____

Have you ever had numbness or tingling down one or both legs? ☐ Yes ☐ No

When? _____

Description _____

Are you under the care of a chiropractor? ☐ Yes ☐ No

Ribs/ Abdomen/ Chest

Do you have a history of rib/ abdomen/ chest injuries? ☐ Yes ☐ No

List dates/times missed _____

Description _____

Were any diagnostic tests performed? ☐ Yes ☐ No (Check all that apply):

☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ X-ray ☐ Other _____

Have you ever had surgery for a rib/ abdomen/ chest injury? ☐ Yes ☐ No

When? _____ Surgeon? _____

Description _____

Hip/Groin

Do you have a history of hip/ groin injuries? ☐ Yes ☐ No

List dates/times missed _____

Description _____

Were any diagnostic tests performed? (Check all that apply):

☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ X-ray ☐ Other _____

Have you ever had surgery for a hip/ groin injury? ☐ Yes ☐ No

When? _____ Surgeon? _____

Description _____

Thigh (including Quadriceps & Hamstrings)

Do you have a history of thigh injuries? ☐ Yes ☐ No

List dates/times missed _____

Description _____

Were any diagnostic tests performed? ☐ Yes ☐ No (Check all that apply):

☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ X-ray ☐ Other _____

Have you ever been hospitalized for a thigh injury? ☐ Yes ☐ No

When? _____ Where? _____

Description _____

Have you ever had surgery of any kind on your thigh(s)? ☐ Yes ☐ No

When? _____ Surgeon? _____

Description _____

Knee

Do you have a history of knee injuries? ☐ Yes ☐ No

List dates/times missed _____

Description _____

Were any diagnostic tests performed? ☐ Yes ☐ No (Check all that apply):

☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ X-ray ☐ Other _____

Have you ever been hospitalized for a knee injury? ☐ Yes ☐ No

When? _____ Where? _____

Have you ever had surgery of any kind on your knee(s)? ☐ Yes ☐ No

When? _____ Surgeon? _____

Description _____

Have you ever /do you presently use a knee brace? ☐ Yes ☐ No

Which Knee? _____ Brand/Model of Brace? _____

Reason for wearing? _____

Ankle/Lower Leg

Do you have a history of ankle injuries? ☐ Yes ☐ No

List dates/times missed _____

Description _____

Were any diagnostic tests performed? ☐ Yes ☐ No (Check all that apply):

☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ X-ray ☐ Other _____

Have you ever been hospitalized for ankle/ lower leg injuries? ☐ Yes ☐ No

When? _____ Where? _____

Description _____

Have you ever had surgery of any kind on your lower leg/ ankle(s)? ☐ Yes ☐ No

When? _____ Surgeon? _____

Description _____

Have you ever/ do you presently tape your ankle(s) or use an ankle brace? ☐ Yes ☐ No

Which ankle? _____ Brand/Model of Brace? _____

Reason for wearing? _____

Foot/Toes

Do you have a history of foot/toe injuries? ☐ Yes ☐ No

List dates/times missed _____

Description _____

Were any diagnostic tests performed? ☐ Yes ☐ No (Check all that apply):

☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ X-ray ☐ Other _____

Have you ever had surgery for a foot/toe injury? ☐ Yes ☐ No

When? _____ Surgeon? _____

Description _____

Asthma

Have you ever been diagnosed with asthma and/ or exercise induced asthma? ☐ Yes ☐ No

Date(s) _____

Please describe _____

Are you presently using/ have you previously used 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 _____

Do you cough, wheeze, or have difficulty breathing during or after exercise? ☐ Yes ☐ No

Is there anyone in your family that has asthma? ☐ Yes ☐ No

Have you ever used an inhaler or taken asthma medicine? ☐ Yes ☐ No

24. Were you born without or are you missing a kidney/eye/testicle/or other organ? ☐ Yes ☐ No

25. Have you ever been told you have kidney disease? ☐ Yes ☐ No

26. Have you had infectious mononucleosis (mono) within the last month? ☐ Yes ☐ No

27. Do you have rashes, pressure sores, or other skin problems? ☐ Yes ☐ No

28. Have you had MRSA skin infection? ☐ Yes ☐ No

29. Do you have reoccurring or frequent headaches? ☐ Yes ☐ No

30. Have you ever had a head injury or concussion? ☐ Yes ☐ No

31. Have you been hit in the head and been confused or lost your memory? ☐ Yes ☐ No

If you answered 'yes' to questions 30 and / or 31, please answer the following questions and explain below.

Description

List Dates/Time Missed _____

Were any diagnostic tests performed? ☐ Yes ☐ No (Check all that apply):

☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ X-ray ☐ Other _____

Do you suffer from headaches? ☐ Yes ☐ No

☐ Everyday? ☐ 1-2 times/week? ☐ 1-2 times/month?

Where are your headaches located?

☐ Front of head ☐ Back of head ☐ Left side of head ☐ Right side of head ☐ All over head

Have you had headaches for more than 3 months? ☐ Yes ☐ No

Description

Do you have history of migraine headaches? ☐ Yes ☐ No

How Often _____

Description

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

Please Describe

Diabetic History

Have you ever been diagnosed with diabetes? ☐ Yes ☐ No

Date _____

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:

Dental History

Do you have a dental cap? ☐ Yes ☐ No

Have you ever had a tooth knocked out? ☐ Yes ☐ No

Have you ever fractured a tooth? ☐ Yes ☐ No

Do you wear orthodontic appliances or other dental appliances? ☐ Yes ☐ No

Do you see a dentist on a regular basis? ☐ Yes ☐ No

Date of last dental exam? _____

32. Have you ever had a seizure? ☐ Yes ☐ No

Description _____

33. Do you have headaches with exercise? ☐ Yes ☐ No

34. Have you ever had numbness, tingling, weakness in your arms or legs after being hit or falling? ☐ Yes ☐ No

35. Have you ever been unable to move your arms/legs after being hit or falling? ☐ Yes ☐ No

36. When exercising in the heat, do you have severe muscle cramps/or become ill? ☐ Yes ☐ No

37. Has a doctor told you that someone in your family has sickle cell trait or sickle cell disease? ☐ Yes ☐ No

38. Have you had any problems with your eyes or vision? ☐ Yes ☐ No

39. Do you wear glasses or contact lenses? ☐ Yes ☐ No

40. Do you wear protective eyewear, such as goggles or a face shield? ☐ Yes ☐ No

41. Are you happy with your weight? ☐ Yes ☐ No

42. Are you trying to gain or lose weight? ☐ Yes ☐ No

43. Has anyone recommended you change your weight or eating habits? ☐ Yes ☐ No

44. Do you limit or carefully control what you eat? ☐ Yes ☐ No

45. Do you have any concerns that you would like to discuss with a doctor? ☐ Yes ☐ No

46. Do you smoke cigarettes/use smokeless tobacco, or use tobacco in any form? ☐ Yes ☐ No

47. Do you use alcohol? ☐ Yes ☐ No If yes, how often? _____

48. Do you feel stressed out? ☐ Yes ☐ No

If yes, do you feel as though you get the necessary support to deal with your stress? _____

49. Are you a vegetarian? ☐ Yes ☐ No

If yes, what type? _____