

U N I V E R S I T Y O F M A I N E A T F O R T K E N T

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? |       |