

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? |  |