HEALTH HISTORY QUESTIONNAIRE

The information provided on this form will help the Athletic Training Staff at Jacksonville Athletic Academy to best care for any injuries and illnesses that you may sustain while participating in intercollegiate athletics. Please answer all the questions to the best of your ability. Accuracy of the information provided is essential. Please be thorough when filling out this form. Please obtain a letter from a treating physician for any prescription medication with medication name, dose and how often it is to be taken. This will be kept on file in the case you are selected for drug testing. Please use blue or black ink to complete this form and complete all sections including all yes/no check boxes and provide explanations for yes answers as applicable.

Name (Last, First) _____ DOB_____ Sport_____

MEDICATIONS (Prescription or Over-the-Counter)	Reason	Dosage/Frequency

ALLERGIES (Please Specify)	YES	NO	Specific Reaction
Medication(s) _____ Food(s)	☐	☐	_____
_____ Seasonal	☐	☐	_____
_____ Stinging Insect	☐	☐	_____
	☐	☐	

Cardiac

Have you ever passed out or nearly passed out DURING/AFTER exercise/practice? Yes ☐ No ☐

Have you ever had discomfort, pain, or pressure in your chest DURING/AFTER exercise/practice? Yes ☐ No ☐

Does your heart race or skip beats DURING /AFTER exercise? Yes ☐ No ☐

Have you ever been diagnosed with? ☐high blood pressure ☐high cholesterol ☐heart murmur ☐heart infection? Yes ☐ No ☐

Has a doctor ever ordered a test for your heart? (for example: ECG or echocardiogram) Yes ☐ No ☐

Has any family member or relative died of heart problems or suddenly before the age of 50? Yes ☐ No ☐

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

Do you or anyone in your family have or been evaluated for Marfan's Syndrome? Yes ☐ No ☐

Have you ever been diagnosed with Pericarditis or Endocarditis? Yes ☐ No ☐

Asthma

Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise/practice? Yes ☐ No ☐

Has a doctor every diagnosed you with Asthma, Exercised Induced Asthma and/or Vocal Cord Dysfunction? Yes ☐ No ☐

Concussion

Have you ever had a head injury/concussion (no matter how minor)? Yes ☐ No ☐

Date of most current: / / Time missed (practice or game): Date of Others:

Have you ever been evaluated by a Doctor for a head injury/concussion? Yes ☐ No ☐

Have you ever had x-ray, MRI, CT, or neurophyschological testing of your head? Yes ☐ No ☐

Have you ever lost consciousness, had memory lose or confusion from a head injury/concussion? Yes ☐ No ☐

Do you suffer from or have a history of regular headaches or migraines? Yes ☐ No ☐

Heat Illness

Have you ever been diagnosed with a heat illness (heat exhaustion, heat stroke)? Yes ☐ No ☐

Have you ever had problems with excessive de-hydration? Yes ☐ No ☐

Have you ever had problems exercising in the heat? Yes ☐ No ☐

Have you ever received intravenous fluid (IV) for a heat related problem? Yes ☐ No ☐

When exercising in the heat, have you ever suffered severe muscle cramps or become ill? Yes ☐ No ☐

General

Were you born without or are you missing a kidney, an eye, a testicle, an ovary, or any other organ? Yes ☐ No ☐

Have you ever been diagnosed with a communicable disease (e.g., Hepatitis A, B, or C, Tuberculosis)? Yes ☐ No ☐

Have you ever been diagnosed with an STD (HIV, Herpes, Gonorrhea, Syphilis, Genital Warts)? Yes ☐ No ☐

Have you ever had seizures, convulsions and/or epilepsy? Yes ☐ No ☐

Have you ever had the chickenpox? If yes, when. Yes ☐ No ☐

If no, have you had the chickenpox vaccine? Yes ☐ No ☐

Have you had a Tetanus shot in the last 5 years? Yes ☐ No ☐

Have you ever been told that you have or been diagnosed with:

ADD/ADHD	Yes ☐ No ☐	Hernia/Sports Hernia	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Kidney Stones	Yes ☐ No ☐
Appendicitis	Yes ☐ No ☐	Liver Disease	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐	Mononucleosis	Yes ☐ No ☐
Bleeding Disorder	Yes ☐ No ☐	Motion Sickness	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Motor Vehicle Accident	Yes ☐ No ☐
Cysts	Yes ☐ No ☐	Urinary Tract Infection	Yes ☐ No ☐
Depression/Anxiety/Bipolar	Yes ☐ No ☐	Rheumatic Fever	Yes ☐ No ☐
Gall Stone	Yes ☐ No ☐	Thyroid Disorders	Yes ☐ No ☐

Explain any Yes answers

Diabetes

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

Do you monitor you blood sugar daily? Yes ☐ No ☐

Have you ever been told you are hypoglycemic? Yes ☐ No ☐

Stomach/Digestion/GI

Have you ever been told you have stomach problems? Yes ☐ No ☐

Do you frequently have: heartburn, indigestion, acid reflux, or constipation? Yes ☐ No ☐

Have you ever had rectal bleeding or blood in your stools? Yes ☐ No ☐

Eyes, Ear, Nose , Throat	
Do you wear glasses or contact lenses?	Yes ☐ No ☐
Have you ever been diagnosed with a retinal detachment?	Yes ☐ No ☐
Do you have any kind of vision defect?	Yes ☐ No ☐
Have you ever had significant problems with your ears, nose or throat?	Yes ☐ No ☐
Have you ever had a perforated eardrum?	Yes ☐ No ☐
Have you ever had ringing in your ears or trouble hearing?	Yes ☐ No ☐
Have you ever had problems with your tonsils or adenoids?	Yes ☐ No ☐
Have you ever had pneumonia, bronchitis or a lung disease?	Yes ☐ No ☐
Have you ever had an abnormal chest x-ray?	Yes ☐ No ☐
Sickle Cell	
Has anyone told you that you or any family member has sickle cell trait or disease?	Yes ☐ No ☐
Have you ever been diagnosed with Sickle Cell Anemiaf?	Yes ☐ No ☐
Females Only	
Have you had any menstrual irregularities in the last 12 months?	Yes ☐ No ☐
Do you take any medication during your menstrual period?	Yes ☐ No ☐

Number of cycles in the last year: Most recent cycle: Longest time between cycles:

Health Habits	
Do you smoke on a regular basis?	Yes ☐ No ☐
Do you use smokeless tobacco (dip, snuff)?	Yes ☐ No ☐
Do you drink alcohol? If yes, how often and amount.	Yes ☐ No ☐
Rate your current stress level? (low 1,2,3,4,5 high)	Yes ☐ No ☐
Have you had a weight change (loss/gain) of greater than 10 lbs in the past year?	Yes ☐ No ☐
Do you feel comfortable with your current weight?	Yes ☐ No ☐
Are you trying to lose or gain weight? Why?	Yes ☐ No ☐
Do you or have you ever had disordered eating habits?	Yes ☐ No ☐
Are you a vegetarian? What type?	Yes ☐ No ☐
Have you ever been diagnosed with insomnia?	Yes ☐ No ☐

Family History

	No History	Mother/Father	Brother/Sister	Grandparent
Anemia	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Depression/Anxiety (Mental Illness)	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Heart Disease (Heart Attack)	☐	☐	☐	☐
Heart Murmur	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐
Neurological Disorder	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐

Neck, Shoulder and Upper Arm

Have you ever had a strain, sprain, fracture, dislocation, pinched nerve, tendinitis, a tear or surgery? (Indicate which Injuries below)

Injury #1_____ Side: R ☐ L ☐ Date:_____

Time Missed:_____ Surgery Required: Y N

What procedures were required, if any? (Check all that apply)

☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Therapy

Injury Side: R ☐ L ☐ Date: _____

Time Missed:_____ Surgery Required: Y ☐ N ☐

What procedures were required, if any? (Check all that apply)

☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Therapy

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

How Many? _____ Dates/Time Missed?_____

Have you ever suffered an injury to your cervical spine and/or neck causing numbness, tingling or weakness in your arms, fingers, or legs? Yes ☐ No ☐

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

☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Other

Dates/Describe:_____ Dates/Time Missed? _____

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

Dates/Describe:_____

Elbow, Forearm, Wrist, Hand, or Fingers

Have you ever had a strain, sprain, fracture, dislocation, tendinitis or surgery? (Indicate which Injuries below)

Injury #1_____ Side: R ☐ L ☐ Date: _____

Time Missed:_____ Surgery Required: Y ☐ N ☐

What procedures were required, if any? (Check all that apply)

☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Therapy

Injury #2_____ Side: R ☐ L ☐ Date: _____

Time Missed:_____ Surgery Required: Y ☐ N ☐

What procedures were required, if any? (Check all that apply)

☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Therapy

Have you ever had any numbness or tingling in your elbow, wrist, hand or fingers? Yes ☐ No ☐

Dates/Describe: _____

Ribs, Thorax, and Chest

Have you ever had a strain, sprain, fracture, bruise, cartilage separation, pneumothorax or surgery? (Indicate which injuries below)

Injury #1_____ Side: R ☐ L ☐ Date: _____
Time Missed: : Surgery Required: Y ☐ N ☐
What procedures were required, if any? (Check all that apply)
☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Therapy

Injury #2_____ Side: R ☐ L ☐ Date: _____
Time Missed:_____ Surgery Required: Y ☐ N ☐
What procedures were required, if any? (Check all that apply)
☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Therapy

Have you ever had Commotio cordis? Yes ☐ No ☐
Dates/Describe? _____

Abdomen

Have you ever had a strain, bruise, abdominal hernia, spleen, liver, kidney intestine injury or surgery? Yes ☐ No ☐

Injury #1_____ Side: R L Date: _____
Time Missed:_____ Surgery Required: Y N
What procedures were required, if any? (Check all that apply)
☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Therapy

Injury #2_____ Side: R L Date: _____
Time Missed:_____ Surgery Required: Y N
What procedures were required, if any? (Check all that apply)
☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Therapy

Lumbar Spine and SI Joint

Have you ever had a strain, sprain, fracture/stress fracture, herniated/bulging disc, spondyloysis or surgery? (Indicate which injuries below)

Injury #1_____ Side: R ☐ L ☐ Date: _____
Time Missed: Surgery Required: Y ☐ N ☐
What procedures were required, if any? (Check all that apply)
☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Therapy

Injury #2_____ Side: R ☐ L ☐ Date: ___/___/___
Time Missed: Surgery Required: Y ☐ N ☐
What procedures were required, if any? (Check all that apply)
☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Therapy

Have you ever had pain, numbness, or tingling go down your leg? Yes ☐ No ☐
Dates/Describe:

Hip, Groin, Thigh

Have you ever had a strain, sprain, fracture/stress fracture, bruise or surgery? (Indicate which injuries below)

Injury #1_____ Side: R☐ L ☐ Date: ___/___/___
Time Missed: Surgery Required: Y ☐ N ☐
What procedures were required, if any? (Check all that apply)
☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Therapy

Injury #2_____ Side: R☐ L ☐ Date: _____
Time Missed: Surgery Required: Y ☐ N ☐
What procedures were required, if any? (Check all that apply)
☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐Therapy

Have you ever had an athletic/sports hernia? Yes ☐ No ☐
Dates/Describe: _____

Knee and Lower Leg

Have you ever had a strain, sprain, fracture/stress fracture, dislocation, tendinitis, a bruise or surgery? (Indicate which injuries below)

Injury #1_____ Side: R ☐ L ☐ Date: _____
Time Missed: _____ Surgery Required: Y ☐ N ☐
What procedures were required, if any? (Check all that apply)
☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Therapy

Injury #2_____ Side: R ☐ L ☐ Date: _____
Time Missed: _____ Surgery Required: Y ☐ N ☐
What procedures were required, if any? (Check all that apply)
☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Therapy

Do you currently wear any type of protective knee brace? Yes ☐ No ☐
Describe: _____

Do you ever get tightness in the front of your leg or tingling in your toes while running? Yes ☐ No ☐
Describe: _____

Ankle, Foot, Toes

Have you ever had a strain, sprain, fracture/stress fracture, tendinitis, a bruise or surgery? (Indicate which injuries below)

Injury #1_____ Side: R ☐ L ☐ Date: _____
Time Missed: _____ Surgery Required: Y ☐ N ☐
What procedures were required, if any? (Check all that apply)
☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Therapy

Injury #2_____ Side: R ☐ L ☐ Date: _____
Time Missed: _____ Surgery Required: Y ☐ N ☐
What procedures were required, if any? (Check all that apply)
☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Therapy

Do you currently wear any type of protective ankle brace or taping? Yes ☐ No ☐
Describe: _____

Please Answer If you answer YES to any of the following, please explain below.

Have you ever had any injury or illness other than those already noted? Yes ☐ No ☐
Have you ever had any injury or illness that required surgery other than those already noted? Yes ☐ No ☐
Have you ever been told by a physician to restrict your sport activity or not to participate in sports? Yes ☐ No ☐
Do you have any concerns that you would like to discuss with a doctor? Yes ☐ No ☐
Are you aware of any reasons why you should not participate in intercollegiate athletics at Millsaps College? Yes ☐ No ☐

Please Explain: _____