# NORTHWEST COLLEGE – MEDICAL HISTORY & PERSONAL DATA QUESTIONNAIRE

**Name (Print)** ______________________________________________ **Exam Date** ____________________
*(First, Middle Initial, Last)*
**Date of Birth** ______/______/______ **Class** **Fr So 3rd** **Sport** ________________________

**Medications & Allergies:** *Please list all prescription, over-the-counter medicines, and supplements (herbal and nutritional) that you are currently taking.*
**Medications:** ____________________________________________________________

**Do you have any allergies?** **Yes** **No** *If yes, please identify specific allergy below.*
**Do you carry an Epi-Pen?** **Yes** **No**
□ **Medicines** □ **Pollens** □ **Food** □ **Stinging Insects**

**Reaction:** ____________________________________________________________

***Instructions:*** *Explain "Yes" answers in Explanation Section. Circle questions you don't know the answer to. Please indicate the questionnaire number, site of injury/illness, left/right, Dr's name, facility of care, and other information that may be important.*

**Gen Medical History** *If yes, (Answer in Explanation Section), what surgery (body part); when (month/year); Dr's name; where (facility or hospital/city); did you do rehabilitation; any ongoing problems?*

**Yes No 1. Has a doctor ever denied or restricted your participation in sports for any reason?**
**Yes No 2. Do you presently have an unrepaired hernia?**
**Yes No 3. Do you have an ongoing medical conditions? (Asthma, hypoglycemia, diabetes, von Willebrand's disease)?** *(Answer in Explanation Section) If yes, what medicines do you take, what form (pills, injection), dosage, and at what frequency?*
**Yes No 4. Have you ever spent the night in a hospital?**
**Yes No 5. Have you ever had surgery?**

**Viral Illness**
**Yes No 6. Have you ever had or currently have any viral infections?** *(Infectious Mono, Hepatitis, Herpes, etc.)*

**Dermatologic Conditions**
**Yes No 7. Do you have or have you ever had any rashes, skin infections, or other skin conditions?** *(Ringworm, Staph, Impetigo, etc.)*

**Allergies & Asthma**
**Yes No 8. Has a doctor ever told you that you or anyone in your family have/has allergies or asthma?**
**Yes No 9. Do you cough, wheeze, or have difficulty breathing during or after exercise?**
**Yes No 10. Have you ever used an inhaler or taken asthma medicine?**
**Yes No 11. Have you gone to the hospital because of asthma during the past year?**

**Cardiovascular Problems**
**Yes No 12. Have you ever passed out or nearly passed out DURING or AFTER exercise?**
**Yes No 13. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? Do you get lightheaded or feel more short of breath than expected during exercise?**
**Yes No 14. Does your heart race or skip beats (irregular beats) during exercise?**
**Yes No 15. Has a doctor ever told you that you have high blood pressure, high cholesterol, Kawasaki disease, a heart murmur, or a heart infection?**
**Yes No 16. Has a doctor ever ordered a test for your heart?** *(i.e. ECG/EKG, echocardiogram)*
**Yes No 17. Do you get more tired or short of breath more quickly than your friends during exercise?**
**Yes No 18. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?**
**Yes No 19. Does anyone in your family have heart disease, pacemaker, implanted defibrillator, or other heart conditions?** *(i.e. Hypertrophic Cardiomyopathy, Dilated Cardiomyopathy, Long QT Syndrome, Marfan Syndrome)*

**Paired Organs**
**Yes No 20. Were you born without or are you missing a paired organ or any other organ?** *(Kidney, eye, testicle, lung)*

**Musculoskeletal Injury** *If yes, (Answer in Explanation Section) when (month/year) was your injury; what body part was injured; seen by a Dr.; did your injury require surgery?*
**Yes No 21. Have you ever had an x-ray for a neck injury?**

Yes No 22. **Have you had persistent upper or lower back pain, current pain, and/or swelling?**
Yes No 23. **Do you regularly use an orthopedic brace or assistive device?**
Yes No 24. **Have you ever had to miss practices or games because of an injury** *(i.e., sprain, muscle or ligament tear, tendinitis, etc.)?*
Yes No 25. **Have you had any fractures, stress fractures, or dislocated joints?**
Yes No 26. **Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, a brace, a cast, or crutches?**
Yes No 27. **Do you have limited motion in any joints or do your joints become painful, swollen, feel warm or look red?**
Yes No 28. **Do you have any history of juvenile arthritis or connective tissue disease?**

**Neurologic Conditions**

Yes No 29. **Have you ever had a head injury or concussion?** *If yes, (Answer in Explanation Section) when (month/year); did you finish the game or practice; did you see a doctor; did you have tests (i.e., x-ray, CT); were you hospitalized?*
Yes No 30. **Have you ever had a hit or blow to the head that caused confusion, prolonged headaches, or memory problems?**
Yes No 31. **Have you ever had an unexplained seizure?**
Yes No 32. **Have you ever had an epileptic seizure or been informed that you might have epilepsy?**
Yes No 33. **Do you have headaches with exercise?** *If yes, frequency, location, migraines, meds*
Yes No 34. **Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?**
Yes No 35. **Have you ever been unable to move your arms or legs after being hit or falling?**

**Heat Illness**

Yes No 36. **Have you ever suffered from heat illness (cramping, exhaustion, stroke)?** *If yes, (Did you vomit, faint, go to Emergency Room, receive an IV)?*
Yes No 37. **Do you get frequent muscle cramps when exercising?**

**Sickle Cell Trait or Disease**

Yes No 38. **Have you been tested for sickle cell trait or disease?**
Yes No 39. **Has a doctor told you that you or a family member has sickle cell trait or disease?**
*If yes, circle: Anemia or Trait or I Do Not Know*

**Ears & Hearing**

Yes No 40. **Have you had any problems with your ears or hearing?** *(Repeat infections, injuries, etc.)*

**Eyes & Vision**

Yes No 41. **Have you had any problems with your eyes or vision?** *(Needed corrections, infections, injuries, etc.)*
Yes No 42. **Do you wear glasses, contact lenses, protective eyewear – goggles, or face shield?**

**Nutritional Concerns**

Yes No 43. **Are you happy with your weight?**
Yes No 44. **Are you trying to gain or lose weight?**
Yes No 45. **Has anyone recommended you change your weight or eating habits?**
Yes No 46. **Have you ever had an eating disorder?**

**General Concerns**

Yes No 47. **Do you have any concerns that you would like to discuss with a doctor?**

**Female Athletes Only**

48. **How old were you when you had your first menstrual period?** ____________
49. **How many periods have you had in the last 12 months?**
Yes No 50. **Do you take birth control medicine?** (*If yes, name; oral, inject, IUD)?*

**Explain "Yes" answers here:** ***Indicate Number, try to give as much information as possible*:** ____________________________

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