NWC ATHLETICS – MEDICAL HISTORY & PERSONAL DATA QUESTIONNAIRE

Name (Print) ______________________________ **Date of Birth** ____/____/____
(First, Middle Initial, Last)

Sport ____________________ **Class 1st 2nd 3rd 4th**

Medications: *List all prescription, over-the-counter medicines, and supplements (herbal and nutritional) that you are currently taking. Include: (name, dosage, frequency)* ______________________________

Do you have any allergies? Yes No *If yes, please identify specific allergy.*

☐ **Food** ____________ ☐ **Medicines** ____________ ☐ **Pollens** ☐ **Stinging Insects** ☐ **Other** ____________

What is your reaction? ______________________________

Do you carry an Epi-Pen? Yes No

Instructions: Complete all questions honestly and thoroughly. Failure to disclose pre-existing injuries/conditions can effect athletes' eligibility. If you answer yes, also answer corresponding questions to give more detailed information. Include information for any care, event, injury, or procedure having taken place in the last 2 years.

General Medical History

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? *If yes, What?(Asthma / Hypoglycemia / Diabetes / von Willebrand's disease / Other)*
Yes No 4. Have you ever spent the night in a hospital?
Yes No 5. Have you ever had surgery? *If yes, What? When? (month, year); Dr? (name, facility, contact); Ongoing problems? Released to participate (documentation required w/in 1yr)*

Viral Illness / Skin Conditions

Yes No 6. Have you ever had or currently have any viral infections? *(Infectious Mono / Hepatitis / Herpes)*
Yes No 7. Do you have or have you ever had any rashes, skin infections, or other skin conditions? *(Ringworm / Staph / Impetigo)*

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 gone to the hospital because of asthma during the past year?

Cardiovascular Problems

Yes No 11. Have you ever passed out or nearly passed out DURING or AFTER exercise? *If yes, Seen by a Dr? (name, facility, contact)*; *Released to participate (documentation required w/in 1yr)*
Yes No 12. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?
Yes No 13. 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? *If yes, Dr? (name, facility, contact); When was your last evaluation? Released to participate (documentation required w/in 1 yr)*
Yes No 16. Has a doctor ever ordered a test for your heart? *If yes, What? (i.e. ECG/EKG, echocardiogram)*; *When? (month, year); Released to participate (documentation required w/in 1 yr)*
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? *If yes, What? (Kidney / Eye / Testicle / Lung)*

Musculoskeletal Injury

Yes No 21. Have you ever had an x-ray for a neck injury? *If yes, When? (month, year); Dr? (name, facility, contact)*; *Did your injury require surgery?*

Yes No 22. Have you had persistent upper or lower back pain, current pain, and/or swelling? *If yes, Where? Any ongoing problems? Released to participate (documentation required w/in 1 yr)*

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? *If yes, What? (Sprain / Strain / Muscle Injury [Tendinitis, Rupture] / Ligament Injury / Other); When? (month, year)*; *Dr? (name, facility, contact)*; *Any ongoing problems? Released to participate (documentation required w/in 1 yr)*

Yes No 25. Have you had any fractures, stress fractures, or dislocated joints? *If yes, What? (fracture / stress fracture / dislocated joint); When? (month, year); Dr? (name, facility, contact)*; *Released to participate (documentation required w/in 2yrs)*

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? *If yes, When? (month, year); Dr? (name, facility, contact)*; *Released to participate (documentation required w/in 1 yr)*

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, When? (month, year); How many? Dr? (name, facility, contact); How long were you out of activity? Tests? (x-ray / CT); Were you hospitalized? Released to participate (documentation required w/in 1 yr)*

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? *If yes, When? (month, year)*

Yes No 32. Have you ever had an epileptic seizure or been informed that you might have epilepsy? *If yes, When was your last seizure? (week / month / year)*; *How long do seizures last? Dr? (name, facility, contact); Released to participate (documentation required w/in 1 yr)*

Yes No 33. Do you have headaches with exercise? *If yes, When? (frequency – how often, how long do they last?); Have you been diagnosed w/migraines?*

Yes No 34. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? *If yes, What? (numbness / tingling / weakness); Where? (arms / legs); How long did sensation last?*

Yes No 35. Have you ever been unable to move your arms or legs after being hit or falling? *If yes, Where? (arms / legs); How long did sensation last? Dr? (name, facility, contact); Released to participate (documentation required w/in 1 yr)*

Heat Illness

Yes No 36. Have you ever suffered from heat illness (cramping, exhaustion, stroke)? *If yes, When? (month, year)*

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?

Ears & Hearing

Yes No 40. Have you had any problems with your ears or hearing? *If yes, What? (repeat infections / injuries / other)*

Eyes & Vision

Yes No 41. Have you had any problems with your eyes or vision? *If yes, What? (Needed corrections / infections / injuries / etc.); Dr? (name, facility, contact)*

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? *If yes, contact our counseling services for continued care.*

Mental Health

Yes No 47. In the past, have you seen a mental health professional to address any mental health and/or emotional issue(s)? (i.e. depression, anxiety, trauma, etc.)

Yes No 48. Are you currently seeing a mental health professional for any mental health and/or emotional issue(s)? *If yes, do you plan on continuing seeing them while at NWC?*

Yes No 49. NWC provides counseling services that address any mental health and/or emotional issue(s). Would you be interested in these services?

NWC Counseling Services, provides a confidential area for students to talk with licensed counselors about any subject that needs addressed in a therapeutic environment. If you wish to contact a counselor, call 307-254-3736 or find information on the website at https://www.nwc.edu/services/counseling/students.html**.**

General Concerns

Yes No 50. Do you have any concerns that you would like to discuss with a doctor?

Female Athletes Only

51. How old were you when you had your first menstrual period? ____________

52. How many periods have you had in the last 12 months?

Yes No 53. Do you take birth control medicine?

If yes, What? (name / oral / inject / IUD)

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

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