

Name _____ Sex _____ DOB _____ Date _____ CID # _____

PURCHASE COLLEGE ATHLETIC HEALTH HISTORY

Sport(s) _____

Personal Physician _____ Phone No. _____

In Case of Emergency, contact:

Name _____ Relationship _____

Phone No. (H) _____ (W) _____

	Yes	No	Explain (Please give details and dates)
At the present time, are you under medical care for any illness, condition or injury?	_____	_____	_____
Have you had a medical illness or injury since our last checkup or sports physical?	_____	_____	_____
Have you ever been disqualified from participating in a sport because of an injury or a medical illness?	_____	_____	_____
Do you have any chronic medical conditions? (anemia, arthritis, asthma, bladder/kidney disease, bleeding disorders, high blood pressure, cancer/leukemia, epilepsy/seizures, diabetes, heart or vascular conditions, eating disorders, weight problems, menstrual disorders, endocrine/hormonal conditions)	_____	_____	_____
Do you have any chronic psychological/emotional/mental conditions? (depression, bi-polar, anxiety, OCD, aspergers, tourettes)	_____	_____	_____
Please list any medications that you are now taking or have taken in the last year (please give names of medications including inhalers, doses and dates that meds were started and stopped). Please include non-prescription (over the counter) medications as well.	_____	_____	_____
Have you ever been hospitalized overnight?	_____	_____	_____
Have you ever had an illness, accident or injury which required you to be seen in an emergency room?	_____	_____	_____
Have you ever had surgery?	_____	_____	_____
Have you ever taken supplements or vitamins to help you gain or lose weight to improve you performance?	_____	_____	_____
Do you have allergies (for example, to pollen, medicine, food or stinging insects)?	_____	_____	_____
Have you ever had a rash or hives develop during exercise?	_____	_____	_____
Have you ever passed out during or after exercise?	_____	_____	_____
Have you ever been dizzy during or after exercise?	_____	_____	_____
Have you ever had chest pain during or after exercise?	_____	_____	_____

Name _____ CID _____ Date _____

Yes No

Explain (Please give details and dates)

Do you get tired more quickly than your friends do, or do you get excessively fatigued during exercise? _____

Have you ever had racing of your heart or skipped heartbeats? _____

Have you had high blood pressure or high cholesterol? _____

Have you ever been told you have a heart murmur? _____

Has any close relative died or had significant disability from heart problems before the age of 50? _____

Do you have any close relatives with any of the following conditions: Marfan Syndrome, hypertrophic cardiomyopathy, dilated cardiomyopathy, long QT syndrome or arrhythmias? _____

Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last 2 months? _____

Has a physician ever denied or restricted your participation in sports for any heart problem? _____

Do you have any current skin problems (for example itching, rashes, acne, warts, fungus, or blisters)? _____

Have you ever had a head injury or concussion? _____

Have you ever been knocked out, become unconscious, or lost your memory? _____

Have you ever had a seizure? _____

Do you have frequent or severe headaches? _____

Have you ever had numbness or tingling in your arms, hands, legs or feet? _____

Have you ever had a stringer, burner or pinched nerve? _____

Have you ever become ill or passed out from exercising in the heat? _____

Do you cough, wheeze or have trouble breathing during or after activity? _____

Do you have asthma? _____

Do you have seasonal allergies that require medical treatment? _____

Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, or hearing aid)? _____

Name _____ CID _____ Date _____

	Yes	No	Explain (Please give details and dates)
Have you had any problems with your eyes or vision?	_____	_____	_____
Do you wear glasses, contacts or protective eyewear?	_____	_____	_____
Have you ever had a sprain, strain, or swelling after injury?	_____	_____	_____
Have you ever broken or fractured any bones or dislocated any joints?	_____	_____	_____
Have you had any other problem with pain or swelling in muscles, tendons, bones or joints?	_____	_____	_____

If yes, circle appropriate area and explain below.

Head	Elbow	Thigh
Neck	Forearm	Knee
Back	Wrist	Shin/Calf
Chest	Hand	Ankle
Shoulder	Finger	Foot
Upper Arm	Hip	

Have you lost, due to trauma or disease, an eye, a kidney or a testicle?	_____	_____
Were you born with only 1 eye, kidney or testicle?	_____	_____
Do you have sickle cell disease/trait?	_____	_____
Do you want to weigh more or less than you do now?	_____	_____
Do you feel extremely stressed out?	_____	_____

Females Only:

When was your first menstrual period? _____

When was your most recent menstrual period? _____

How much time do you usually have from the start of one period to the start of another? _____

How many periods have you had in the past year? _____

What was the longest time between periods in the past year? _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

(Signature of Athlete) _____

(Signature of parent/guardian)
if < 18 years old

_____/_____/_____
(Date)

Physician name: _____

Physician signature: _____

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