ATHLETIC MEDICAL QUESTIONNAIRE

Lawrence University Athletic Training Services • PO Box 599 • Appleton, WI 54912-0599
phone: 920-832-6762 • fax: 920-832-7349

(Please print clearly)

Name (include M.I.) ____ Date________________

Sport ____ D.O.B. _____/_____/________

Class Year Fr ____ So ____ Jr ____ Sr ____ LU ID#______________________

School address ______________________________ Home Address ___________________________

______________________________ ___________________________

Cell phone____________________ Home phone _________________________

****

__Please explain 'yes' answers__ ***__Circle your choice__***

1. Have you ever been hospitalized?_____________________________________ Yes No
2. Have you ever had surgery? ____ Yes No
3. Are you presently taking any over-the-counter medications or supplements? Yes No
   ____
   Are you presently taking any prescription medications? __________________ Yes No
4. Do you have any allergies (medicine, food, etc.) ________________________ Yes No
   ____
5. Have you ever passed out or nearly fainted during exercise? Yes No
   Have you ever had chest discomfort or chest pain during exercise? Yes No
   Do you tire quicker than your friends during exercise? Yes No
   Have you ever been told you have a heart murmur? Yes No
   Have you ever had high blood pressure? Yes No
   Have you ever had racing of your heart or skipped beats? Yes No
   Has anyone in your family died of heart problems or sudden death before age 50? Yes No
   Have you been told you have sickle-cell anemia? Yes No
   Do you have a close relative under age 50 with disability from heart disease? Yes No
   Do you or any of your family have knowledge of cardiac conditions?
   (Marfan's syndrome, cardiomyopathy, long QT syndrome) Yes No
   Are you presently taking any prescription medications on a regular basis for your heart, blood pressure, diabetes, or seizures? ________________________ Yes No
6. Do you have any skin problems (itching, moles, etc.) ____________________ Yes No
7. Have you ever had a concussion? ____________________________________ Yes No
   If yes, how many and when? _____________________________________
   Have you ever had a seizure? ____ Yes No
   Have you ever had a 'stinger' or 'burner'? ____________________________ Yes No
8. Have you ever injured (sprained, dislocated, fractured, etc.) one of the following structures (indicate R or L):

_____hand _____wrist _____forearm _____elbow _____arm _____shoulder
_____neck _____chest _____back _____hip _____thigh _____knee
_____shin _____calf _____ankle _____foot

Please indicate type of injury, date of injury, and any limitations or continuing problems:

____

____

9. Have you ever had heat cramps? Yes No
   Have you ever been dizzy or passed out in the heat? Yes No

10. Have you ever had one of the following in the last 12 months (note ones you have or have had with a check mark):

_____mononucleosis _____hepatitis _____asthma _____tuberculosis
_____diabetes _____headaches (freq) _____eye injury _____stomach ulcer

11. Have you been advised by a physician or by your parents not to participate in athletic events? Yes No
12. Have you been treated for a disease or illness during the past 12 months? Yes No
    ____
13. Are you currently under the care of a physician? ________________________ Yes No
    ____
14. Have you been found to have only one organ of usually paired organs Yes No
    (ex.: kidney, eye)? ____
15. Do you wear ____ Glasses ____ Contacts
    Do you wear ____ Dental bridges ____ Plates ____ Braces
16. Do you use ____Special pads ____ Braces ___________________________
17. When was your last tetanus shot (date)? _______________________

Confidential Health Questionnaire

Have you ever been treated for anemia? Yes No
How many meals do you eat each day? _____ How many snacks? _____
Are there certain food groups you refuse to eat (ex.: meats, breads) _____________________________
Have you ever been on a diet? Yes No
What is your present weight? __________ Are you happy with this weight? Yes No
If not, what would you like to weigh? __________
Have you ever tried to control your weight by the following methods? (check all that apply):
_____vomiting _____diuretics _____diet pills _____using laxatives
Have you ever expressed a concern that you might have an eating disorder like bulimia or anorexia? Yes No
Has anyone ever expressed a concern that you might have an eating disorder? Yes No
Have you been treated for an eating disorder? Yes No
Do you have questions about healthy ways to control weight? Yes No

For Men Only

Do you perform testicular exams on a regular basis? _________________________ Yes No

For Women Only

How old were you when you had your first menstrual period? ____________________
How often do you have a period? ____
How long do your periods last? ____
How many periods have you had in the last 12 months? _________________________
Do you ever experience cramps during your period? Yes No
If so, how do you treat them? ____
Do you perform self breast exams on a regular basis? _________________________ Yes No

With my signature, I, the undersigned, assure that the above is correct to the best of my knowledge.

____ ____________________________

Signature of Athlete Date