TENNESSEE STATE UNIVERSITY SPORTS MEDICINE
MEDICAL HISTORY QUESTIONNAIRE

The information provided on this form will help the Sports Medicine Staff at Tennessee State University 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. This will expedite your athletic medical clearance upon your arrival to campus each fall by our medical team.

Year of Eligibility: ☐ FR ☐ SO ☐ JR ☐ SR ☐ Redshirt (if yes) **Date:** _____/_____/_____

First Name: _____ **Last Name:** _____ **Date of Birth:** _____/_____/_____

Social Security Number: _____-_____-_____ **TSU ID:** _____ **Sport:** _____

Home Address: _____ **Campus/Local Address:** _____

City: _____ **City:** _____

State: _____ **State:** _____

Zip: _____ **Zip:** _____

Home Phone: _____-_____-_____ **Local Phone:** _____-_____-_____

Cell Phone: _____-_____-_____ **Email:** _____

Parent/Guardian Contact Information:

Father's Name: _____ **Mother's Name:** _____

Home Address: _____ **Home Address:** _____

City: _____ **City:** _____

State: _____ **State:** _____

Zip: _____ **Zip:** _____

Home Phone: _____-_____-_____ **Home Phone:** _____-_____-_____

Work Phone: _____-_____-_____ **Work Phone:** _____-_____-_____

Father's Cell Phone: _____-_____-_____ **Mother's Cell Phone:** _____-_____-_____

Father's Email: _____ **Mother's Email:** _____

ALTERNATE EMERGENCY CONTACT, if not parent/guardian:

Name:_____ **Cell Phone:** _____-_____-_____

Relationship to Athlete: _____ **Home Phone:** _____-_____-_____

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DIRECTIONS: Please check "YES" or "NO" for all items. *Explain* all "YES" responses in the space provide.

Cardiovascular:

1. Have you ever passed out or nearly passed out DURING or AFTER exercise / practice? Y: ☐ N: ☐
   - Dates/Describe: _____
2. Have you ever had discomfort, pain, or pressure in your chest DURING or AFTER exercise / practice? Y: ☐ N: ☐
   - Dates/Describe: _____
3. Have you ever had shortness of breath DURING or AFTER exercise / practice? Y: ☐ N: ☐
   - Dates/Describe: _____
4. Have you ever had the feeling of your heart racing or skipping beats DURING or AFTER exercise / practice? Y: ☐ N: ☐
   - Dates/Describe: _____
5. Has your doctor ever told you that you have (check all that apply)? Y: ☐ N: ☐
   - ☐ High blood pressure ☐ High cholesterol ☐ A heart murmur ☐ A heart infection
   - Dates/Describe: _____
6. Does anyone in your family have a history of the following (check all that apply)? Y: ☐ N: ☐
   - ☐ High blood pressure ☐ High cholesterol ☐ A heart murmur ☐ A heart infection
   - Who/Describe: _____
7. Has a doctor ever ordered an electrocardiogram (EKG) and/or echocardiogram (ECHO) of your heart? Y: ☐ N: ☐
   - Dates/Describe: _____
8. Has any family member or relative died of heart problems and/or of sudden death before age 50? Y: ☐ N: ☐
   - Who/Describe: _____
9. Does anyone in your family have Marfan syndrome? Who: _____ Y: ☐ N: ☐

Allergies:

10. Are you allergic to and/or ever had an unfavorable reaction to any of the following (check all that apply)? Y: ☐ N: ☐
    - ☐ Medications ☐ Seasonal ☐ Foods ☐ Stinging insects
    - Dates/Describe: _____
11. Are you presently taking/have you previously taken any allergy medications? Y: ☐ N: ☐
    - Medication/Form/Dosage/Frequency:_____

Asthma:

12. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise / practice? Y: ☐ N: ☐
    - Describe: _____
13. Has your doctor every diagnosed you with Asthma and/or Exercised Induced Asthma? Y: ☐ N: ☐
    - Dates/Describe: _____
14. Are you presently taking/have you previously taken any Asthma medications / use an inhaler? Y: ☐ N: ☐
    - Medication/Form/Dosage/Frequency:_____

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Head/Concussion/Cervical Spine:

15. Have you ever suffered a head injury/concussion (no matter how minor) causing confusion, memory loss, or unconsciousness? Y: ☐ N: ☐
    - Dates/Describe: _____
    - Time missed (practice or games):_____
16. Have you ever been evaluated by a Doctor for a head injury/concussion? Y: ☐ N: ☐
    - Name of Doctor: _____ Dates/Describe:_____
    - Were any diagnostic tests performed? (check all that apply)
      ☐ X-ray ☐ MRI ☐ CT-Scan ☐ Neuropsychological Testing
17. Do you have a history of Migraine Headaches? Y: ☐ N: ☐
    - How often? _____ Describe: _____
    - Medications taken for Migraines? _____
18. Do you have headaches with exercise? Y: ☐ N: ☐
    - Dates/Describe: _____
19. Have you ever suffered an injury to your neck causing numbness, tingling or weakness in your arms, fingers, or legs? Y: ☐ N: ☐
    - Dates/Describe: _____
    - Time missed (practice or games): _____
    - Were any diagnostic tests performed? (check all that apply)
      ☐ X-ray ☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ Other: _____
20. Have you ever been unable to move your arms or legs after being hit or falling? Y: ☐ N: ☐
    - Dates/Describe: _____
21. Have you ever had "Burners", "Stingers", or Brachial Plexus injuries? Y: ☐ N: ☐
    - How Many? _____ Dates/Time Missed? _____
22. Have you ever worn or been advised to wear a Neck Roll, Neck Collar, "Cowboy Collar" and/or Helmet Restrictor Plate? Y: ☐ N: ☐
    - Dates/Describe: _____

Eyes:

23. Do you routinely suffer from blurred vision, double vision, tunnel vision, and/or any other vision problems? Y: ☐ N: ☐
    - Describe: _____
24. Do you wear glasses or contact lenses? Describe: _____ Y: ☐ N: ☐
25. Do you wear protective eye wear such as goggles or a face shield? Describe: _____ Y: ☐ N: ☐

Abdomen:

26. Were you born without or are you missing a kidney, an eye, a testicle, an ovary, or any other organ? Y: ☐ N: ☐
    - Dates/Describe: _____
27. Do you routinely suffer from severe or recurrent abdominal pain? Y: ☐ N: ☐
    - Describe: _____
28. Do you suffer from any type of urological or genital disorder? Y: ☐ N: ☐
    - Describe: _____

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Dermatological:

29. Do you have any skin problems that we should be aware of (e.g. pressure sores, rashes, herpes, skin infection, etc.)? Y: ☐ N: ☐
    - Dates/Describe:_____
30. Have you been diagnosed with a MRSA or Staphylococcus infection? Y: ☐ N: ☐
    - Dates/Describe:_____

Heat Illness:

31. When exercising in the heat have you ever suffered severe muscle cramps or become ill? Y: ☐ N: ☐
    - Dates/Describe:_____
32. Have you ever received intravenous fluids (IV) for a heat related problem? Y: ☐ N: ☐
    - Dates/Describe:_____

Diabetic History:

33. Have you ever been diagnosed with diabetes? Y: ☐ N: ☐
    - Dates:_____
34. Does anyone in your family have a history of diabetes? Y: ☐ N: ☐
    - Who/Describe:_____
35. Are you presently taking or have you taken any diabetic medications? Y: ☐ N: ☐
    - Medication/Form/Dosage/Frequency:_____
36. Do you monitor your blood sugar daily? Y: ☐ N: ☐
    - How Many Times per Day? _____ What is your average level? _____

Sickle Cell Anemia:

37. Has a doctor told you that you or any member of your family has sickle cell trait or disease? Y: ☐ N: ☐
    - Dates/Describe:_____
38. Have you ever been tested for Sickle Cell Anemia that you are aware of? Y: ☐ N: ☐
    - Dates/Result:_____

Females Only:

39. How old were you when you started your menstrual periods? _____Years
40. On average, how many days are there between your menstrual periods? _____Days
41. Have you had any menstrual irregularities in the last 12 months? Y: ☐ N: ☐
    - Number of cycles in last year: _____ Most recent cycle? _____ Longest time between cycles? _____
42. Do you exhibit premenstrual symptoms? Y: ☐ N: ☐
    - On a scale from 1-10 please indicate severity of symptoms with 10 being the worst _____of 10
43. Do you take birth control pills? If yes, what brand_____ Y: ☐ N: ☐
44. Have you had a pelvic examination within the last year? Y: ☐ N: ☐
45. Any history of stress fractures? Y: ☐ N: ☐
    - Dates/Areas: _____

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Orthopedic Injury History: Please answer each question and explain injuries in the space provided.

46. Have you ever fractured any bones, had any joint dislocations or stress fractures? (If yes, check body parts below) Y: ☐ N: ☐

☐ Chest/Ribs ☐ Shoulder ☐ Upper arm ☐ Forearm/Wrist ☐ Hip/Pelvis ☐ Ankle/Lower Leg

☐ Low Back ☐ Face/Jaw/Teeth ☐ Elbow ☐ Hand/Fingers ☐ Knee ☐ Thigh ☐ Foot/Toes

- **Injury #1:** _____ **Side:** Right: ☐ Left: ☐ What procedures were required, if any? (check all)
  Date: _____ Time Missed: _____ ☐ X-Ray ☐ MRI ☐ CT-Scan
  Surgery Required? _____ If so, Doctor? _____ ☐ Bone Scan ☐ Casting ☐ Therapy
- **Injury #2:** _____ **Side:** Right: ☐ Left: ☐ What procedures were required, if any? (check all)
  Date: _____ Time Missed: _____ ☐ X-Ray ☐ MRI ☐ CT-Scan
  Surgery Required? _____ If so, Doctor? _____ ☐ Bone Scan ☐ Casting ☐ Therapy
- **Injury #3:** _____ **Side:** Right: ☐ Left: ☐ What procedures were required, if any? (check all)
  Date: _____ Time Missed: _____ ☐ X-Ray ☐ MRI ☐ CT-Scan
  Surgery Required? _____ If so, Doctor? _____ ☐ Bone Scan ☐ Casting ☐ Therapy

47. Have you ever injured a muscle (strain) or ligament (sprain) or cartilage (tear)? (If yes, check body parts below) Y: ☐ N: ☐

☐ Chest/Ribs ☐ Shoulder ☐ Upper arm ☐ Forearm/Wrist ☐ Hip/Groin ☐ Ankle/Lower Leg

☐ Low Back ☐ Hamstring ☐ Elbow ☐ Hand/Fingers ☐ Knee ☐ Quad ☐ Foot/Toes

- **Injury #1:** _____ **Side:** Right: ☐ Left: ☐ What procedures were required, if any? (check all)
  Date: _____ Time Missed: _____ ☐ X-Ray ☐ MRI ☐ CT-Scan
  Surgery Required? _____ If so, Doctor? _____ ☐ Injection ☐ Bracing ☐ Therapy
- **Injury #2:** _____ **Side:** Right: ☐ Left: ☐ What procedures were required, if any? (check all)
  Date: _____ Time Missed: _____ ☐ X-Ray ☐ MRI ☐ CT-Scan
  Surgery Required? _____ If so, Doctor? _____ ☐ Injection ☐ Bracing ☐ Therapy
- **Injury #3:** _____ **Side:** Right: ☐ Left: ☐ What procedures were required, if any? (check all)
  Date: _____ Time Missed: _____ ☐ X-Ray ☐ MRI ☐ CT-Scan
  Surgery Required? _____ If so, Doctor? _____ ☐ Injection ☐ Bracing ☐ Therapy

48. Have you suffered any other injuries not listed above that required you to have surgery? (if yes, list below) Y: ☐ N: ☐

- Dates/Describe: _____
  Name of Doctor: _____ Time Missed: _____
- Dates/Describe: _____
  Name of Doctor: _____ Time Missed: _____
- Dates/Describe: _____
  Name of Doctor: _____ Time Missed: _____

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Weight:

49. Have you had a weight change (loss or gain) of greater than 10 pounds in the past year? Y: ☐ N: ☐

50. Do you regularly lose weight to participate your sport? Y: ☐ N: ☐

- Please Explain:_____

51. Are you trying to lose or gain weight? Why? Y: ☐ N: ☐

- Please Explain:_____

52. Has anyone recommended you change your weight or eating habits? Y: ☐ N: ☐

- Who/Why? _____

53. Have you ever felt forced to limit your food intake due to concerns about your weight and/or body size? Y: ☐ N: ☐

- Please Explain:_____

54. Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorders? Y: ☐ N: ☐

- Please Explain:_____

55. Would you like to meet with a doctor to discuss your nutritional needs or eating habits? Y: ☐ N: ☐

Prescription Medications:

Please List **ALL** Prescription That You Are **CURRENTLY** Taking:

MEDICATION	PURPOSE	DOSAGE	DATE(S)

Supplements:

Please List **ALL** Supplements That You Are **CURRENTLY** Taking:

SUPPLEMENT	PURPOSE	DOSAGE	DATE(S)

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Please Answer: If you answer "YES" to any of the following question, please explain below:

56. Have you ever had any injury or illness other than those already noted?	Y: ☐	N: ☐
57. Have you ever had any injury or illness that required surgery other than those already noted?	Y: ☐	N: ☐
58. Do you have any ongoing or chronic illnesses?	Y: ☐	N: ☐
59. Have you ever been hospitalized overnight?	Y: ☐	N: ☐
60. Have you ever been told by a physician to restrict your sports activity or not to participate in sport?	Y: ☐	N: ☐
61. Are you currently under a physician's care for any medical conditions?	Y: ☐	N: ☐
62. Have you ever been under the care of a psychiatrist and/or psychologist?	Y: ☐	N: ☐
63. Have you ever had a stomach and/or duodenal ulcer?	Y: ☐	N: ☐
64. Have you ever had a viral infection (i.e. mononucleosis, myocarditis, etc.) within the past six (6) months?	Y: ☐	N: ☐
65. Have you ever had seizures, convulsions, and/or epilepsy?	Y: ☐	N: ☐
66. Have you ever had gall bladder disease and/or a urinary problem?	Y: ☐	N: ☐
67. Have you ever been diagnosed with a communicable disease (e.g. STD, HIV, Hepatitis A, B, or C, Herpes, Tuberculosis)?	Y: ☐	N: ☐
68. Do you have ringing in your ears or trouble hearing?	Y: ☐	N: ☐
69. Do you have frequent ear infections or nosebleeds?	Y: ☐	N: ☐
70. Have you ever had the chickenpox? If yes, when? _____	Y: ☐	N: ☐
71. Have you ever had an abnormal chest x-ray and/or pneumonia?	Y: ☐	N: ☐
72. Are you a vegetarian? If yes, what type? _____	Y: ☐	N: ☐
73. Do you have any concerns that you would like to discuss with a doctor?	Y: ☐	N: ☐
74. Are you aware of any reasons why you should not participate in intercollegiate athletics at Tennessee State University?	Y: ☐	N: ☐

Please Explain: