



Bridgewater College

Athletic Training Program

Medical History Questionnaire

Last Name		First Name		Middle Name
Sport(s)	Class	Age	Date of Birth	Social Security Number
Parent/Guardian's Name		Home Address		Home Phone Number

The following information is vitally important for the screening of athletes for sports participation. Please answer **ALL** questions honestly. The medical information that you share is kept confidential and will only be shared with authorized athletic training staff and medical providers. This medical history **MUST** be completed prior to athletic participation.

Check all that apply to your current or past medical history.

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Absent organ | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hernia | <input type="checkbox"/> Physical handicap |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dizziness | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Serious bone/joint injury |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Latex sensitivity | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gastric reflux | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Malaria | |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Migraines | |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mononucleosis | |

Please check "yes" or "no" for the following questions. If answering "yes" please explain in the provided space found on the back of this sheet.

- | | | |
|--------------------------|--------------------------|---|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Have you had a medical illness in the past 12 months? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Have you been hospitalized overnight? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Have you undergone surgery for a medical condition or injury? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you experience frequent headaches? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you have missing organs? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Has any of your family members died of heart problems or sudden death before age 50? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you ever experience shortness of breath during or after exercise? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you experience wheezing during or after exercise? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you use an inhaler? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you have a skin condition? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Do you have hearing problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you have problems with your vision? |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you wear glasses or contacts while participating in athletics? |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Are you currently taking over-the-counter medications? |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Are you currently taking prescription medications? |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Are you currently taking herbal or nutritional supplements? |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Are you allergic to any medications? |
| <input type="checkbox"/> | <input type="checkbox"/> | 18. Are you allergic to any foods? |
| <input type="checkbox"/> | <input type="checkbox"/> | 19. Are you allergic to latex products? |
| <input type="checkbox"/> | <input type="checkbox"/> | 20. Do you have any other allergies not described above? |

Please check "yes" or "no" for the following questions. If answering "yes" please explain in the provided space at the end of the page.

YES NO

- 21. Has your weight changed within the last 12 months?
- 22. Do you feel that you need to gain or lose weight?
- 23. Have you ever tried to use diet pills, diuretics, laxatives, vomiting, or similar technique to lose weight?
- 24. Do you experience irregular menstrual periods?
- 25. When was the last time you saw a dentist?
- 26. Do you use tobacco products?
- 27. Within the last year, have you been seriously injured while participating in athletics?
- 28. Have you suffered any foot or ankle injuries?
- 29. Have you suffered any lower leg or shin injuries?
- 30. Have you suffered any knee, thigh or hip injuries?
- 31. Have you suffered any back injuries?
- 32. Have you suffered any abdominal or chest injuries?
- 33. Have you suffered internal injuries?
- 34. Have you suffered shoulder, arm or elbow injuries?
- 35. Have you suffered wrist, hand or finger injuries?
- 36. Have you suffered ear, nose or throat injuries?
- 37. Have you suffered a stress fracture or other type of fracture?
- 38. Have you suffered a head injury or concussion? How many? When?
- 39. Have you lost consciousness due to a head injury or concussion? How long?
- 40. Have you experienced memory or concentration problems due to a head injury or concussion?
- 41. Have you missed a practice or competition due to a head injury or concussion?
- 42. Do you currently experience problems due to a past head injury or concussion?
- 43. Have you become ill from exercising in the heat?
- 44. Have you received an x-ray, MRI or bone scan within the last 12 months?
- 45. Has a medical professional recommended the use of tape or other protective bracing while participating in athletics?
- 46. Has a medical professional recommended orthotic devices or arch supports for participation in athletics?
- 47. Have you been advised by a medical professional NOT to participate in athletics?
- 48. Have you NOT been allowed to participate in an athletic event because of an injury or medical condition?
- 49. Do you know of any health reason why you should NOT participate in Bridgewater College athletics?

Explain all "yes" answers or provide other pertinent medical information in the following space:

I, hereby, state to the best of my knowledge, the answers provided are correct. I have not withheld any health information important to my safety.

Signature of Athlete Date

**Signature of Parent/Guardian Date
 **Needed if athlete is under 18 years of age