

# Columbia College Athletics

## Health History

Sport \_\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex M or F

School or Local Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Local Phone Number (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_-\_\_\_\_

**Mother/Guardian** \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Father/Guardian** \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Emergency Contact** (other than above) \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_ Relationship \_\_\_\_\_

**FAMILY HISTORY: HAS ANY BLOOD RELATIVE EVER HAD:** (Please clarify who (i.e. grandma on mom's side, grandfather on dad's side, etc)

HISTORY	YES	NO	COMMENTS
Sudden Death before age 55			
Heart Disease			
High Blood Pressure/Hypertension			
Marfan Syndrome			
Diabetes			
Epilepsy			
Hemophilia, Sickle Cell Disease, Leukemia			
Kidney Stones			
Thyroid Disease/Goiter			
Gout			
Tuberculosis			
Drug/Alcohol Dependency			

**CURRENT MEDICATIONS/VITAMINS/NUTRITIONAL SUPPLEMENTS** (prescription and over-the-counter)

1.	5.
2.	6.
3.	7.
4.	8.

**DATE OF LAST TETANUS SHOT:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**ALLERGIES:**

DRUG	YES	NO
Penicillin		
Sulfa		
Codeine		
Aspirin/Anti-Inflammatories		
Insect Bites/Stings		
Hay Fever		
Tetanus Antitoxin/Serum		
Any Foods: (explain on right)		
Latex		
Other Drugs: (explain on right)		

**Explain/Reaction:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PERSONAL MEDICAL HISTORY: HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?**

HISTORY	YES	NO	HISTORY	YES	NO
Abnormal Bruising/Bleeding			Migraine/Headaches		
Alcohol/Drug Problem/Dependency			Mono		
Anemia/Low Blood Counts			Pneumonia/Frequent Respiratory Infections		
Arthritis/Gout/Joint Problems			Pregnancy		
Asthma/Breathing Problems			Rheumatic Fever/Heart Disease		
Birth Defects			Seizure Disorder/Epilepsy		
Cancer/Tumor/Growth/Cyst			Sexually Transmitted Disease		
Chicken Pox			Sickle Cell Disease		
Constipation/Diarrhea/Hemorrhoids			Sinus Infections/Nasal Polyps/Nose Fracture		
Depression/Anxiety/Nervous Breakdown			Skin Disease/Birthmarks		
Diabetes			Spleen/Liver Injury		
Hepatitis/Liver Problems/Jaundice			Stomach Problems (ulcer, bleeding)		
Hernia			Thyroid Disease/Goiter		
Kidney Stones/Disease/Injury			Tuberculosis		
Meningitis			Urinary Problems (blood, recurrent infections)		
Herpes (oral or genital)			More than 3 fractures as a child		

**Explain all "YES" answers:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**INTERNAL/SURGICAL HISTORY:**

QUESTION	YES	NO
Were you <b>born</b> WITHOUT a complete set of paired organs (eyes, kidneys, ovaries/testes, lungs)?		
Have you ever had <b>surgery</b> to repair/remove any organ (hernia, tonsils, appendix, spleen, etc)?		

**Explain all "YES" answers:** \_\_\_\_\_  
 \_\_\_\_\_

**HEAD INJURY HISTORY: Have you ever had any of the following head problems:**

HISTORY	YES	NO	HISTORY	YES	NO
Concussion			Knocked out/Unconscious		
Dazed/Dizzy			Recurrent headaches		
Skull fracture			X-rays/CT/MRI		
Hospitalization/Surgery			Missed practice/game time		

**Explain all "YES" answers:** \_\_\_\_\_  
 \_\_\_\_\_

**NECK INJURY HISTORY: Have you ever had any of the following neck problems:**

HISTORY	YES	NO	HISTORY	YES	NO
Sprain/Strain/Stretch			Arm goes "dead" after contact		
Disc injury/Referred pain			Neck injection		
Fracture/Dislocation			X-rays/CT/MRI		
Hospitalization/Surgery			Missed practice/game time		
Pinched nerve/Burner/Stinger			Other (explain):		

**Explain all "YES" answers:** \_\_\_\_\_  
 \_\_\_\_\_

**SHOULDER INJURY HISTORY: Have you ever had any of the following shoulder problems:**

HISTORY	YES	NO	HISTORY	YES	NO
Sprain/Strain			A-C separation		
Bursitis/Tendonitis			Dislocation/Subluxation (partial dislocation)		
Pain with overhead activity			Sternoclavicular injury		
Fracture (collar bone/rib/shoulder)			X-rays/CT/MRI		
Hospitalization/Surgery/Arthroscopy			Missed practice/game time		

**Explain all "YES" answers:** \_\_\_\_\_

**ARM/FOREARM INJURY HISTORY: Have you ever had any of the following arm/forearm problems:**

HISTORY	YES	NO	HISTORY	YES	NO
Sprain/Strain			Bursitis/Tendonitis		
Fracture/Dislocation/Cast/Splint			X-rays/CT/MRI		
Hospitalization/Surgery/Arthroscopy			Missed practice/game time		

**Explain all "YES" answers:** \_\_\_\_\_

**ELBOW INJURY HISTORY: Have you ever had any of the following elbow problems:**

HISTORY	YES	NO	HISTORY	YES	NO
Sprain/Strain			Bursitis/Tendonitis/Locking		
Fracture/Dislocation/Cast/Splint			X-rays/CT/MRI		
Hospitalization/Surgery/Arthroscopy			Missed practice/game time		

**Explain all "YES" answers:** \_\_\_\_\_

**WRIST INJURY HISTORY: Have you ever had any of the following wrist problems:**

HISTORY	YES	NO	HISTORY	YES	NO
Sprain/Strain			Bursitis/Tendonitis/Locking		
Fracture/Dislocation/Cast/Splint			X-rays/CT/MRI		
Hospitalization/Surgery/Arthroscopy			Missed practice/game time		

**Explain all "YES" answers:** \_\_\_\_\_

**HAND/FINGER INJURY HISTORY: Have you ever had any of the following hand/finger problems:**

HISTORY	YES	NO	HISTORY	YES	NO
Sprain/Strain			Bursitis/Tendonitis/Locking		
Fracture/Dislocation/Cast/Splint			X-rays/CT/MRI		
Hospitalization/Surgery/Arthroscopy			Missed practice/game time		

**Explain all "YES" answers:** \_\_\_\_\_

**PELVIS/HIP INJURY HISTORY: Have you ever had any of the following pelvis/hip problems:**

HISTORY	YES	NO	HISTORY	YES	NO
Sprain/Strain/Torn muscle			Hip pointer/bruise		
Bursitis/Tendonitis/Locking			X-rays/CT/MRI		
Fracture/Dislocation/Cast/Splint			Missed practice/game time		
Hospitalization/Surgery/Arthroscopy			Other (please explain):		

**Explain all "YES" answers:** \_\_\_\_\_

**LOWER BACK INJURY HISTORY: Have you ever had any of the following lower back problems:**

HISTORY	YES	NO	HISTORY	YES	NO
Sprain/Strain/Stretch			Disc injury/Pinched nerve/Referred pain		
Leg pain/numbness/weakness			Back injection		
Fracture/Dislocation			X-rays/CT/MRI		
Hospitalization/Surgery			Missed practice/game time		

**Explain all "YES" answers:** \_\_\_\_\_

**KNEE INJURY HISTORY: Have you ever had any of the following knee problems:**

HISTORY	YES	NO	HISTORY	YES	NO
Sprain/Strain			Bursitis/Tendonitis/Jumper's Knee		
Torn cartilage/Meniscal injury			Knee locking/giving way		
Osgood-Schlatters disease			Knee cap dislocation/injury		
Pain with squatting/stairs			Chondromalacia/Grinding		
Fracture/Dislocation			Brace/Cast/Splint worn		
Knee injection			X-rays/CT/MRI		
Hospitalization/Surgery/Arthroscopy			Missed practice/game time		

**Explain all "YES" answers:** \_\_\_\_\_

**LEG INJURY HISTORY: Have you ever had any of the following leg problems:**

HISTORY	YES	NO	HISTORY	YES	NO
Sprain/Strain			Shin splits/Calf pain/tightness with activity		
Bursitis/Tendonitis			Stress fracture		
Achilles tendon pain/injury			Cast/Splint worn		
Leg injection			X-rays/CT/MRI		
Fracture/Dislocation			Missed practice/game time		
Hospitalization/Surgery/Arthroscopy			Other (explain):		

**Explain all "YES" answers:** \_\_\_\_\_

**ANKLE INJURY HISTORY: Have you ever had any of the following ankle problems:**

HISTORY	YES	NO	HISTORY	YES	NO
Sprain/Strain			Bursitis/Tendonitis/Locking		
Instability/Gives out			Ankle injection		
Weakness			Cast/Splint		
Fracture/Dislocation			X-rays/CT/MRI		
Hospitalization/Surgery/Arthroscopy			Missed practice/game time		

**Explain all "YES" answers:** \_\_\_\_\_

**FOOT/TOE INJURY HISTORY: Have you had any of the following foot/toe problems:**

HISTORY	YES	NO	HISTORY	YES	NO
Sprain/Strain			Bursitis/Tendonitis/Locking		
Turf toe			Foot injection		
Weakness			Heel pain		
Fracture/Dislocation/Cast/Splint			X-rays/CT/MRI		
Hospitalization/Surgery/Arthroscopy			Missed practice/game time		

**Explain all "YES" answers:** \_\_\_\_\_

**MISCELLANEOUS: Have you ever**

HISTORY	YES	NO
Missed a game due to illness?		
Had pins, staples, or wires in your body?		

<p>Do you have any body piercings?                  If yes, where? _____                  _____                  Explain if necessary:</p>
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**CARDIAC HISTORY: Have you ever had any of the following problems/conditions?**

HISTORY	YES	NO	HISTORY	YES	NO
Felt dizzy, light-headed, or passed out during or after exercise?			Had chest pain, tightness, pressure, or any discomfort in the chest during exercise?		
Had irregular hear beats or palpitations?			Diagnosed with a heart murmur?		
Had high blood pressure?			Been told you have a "heart problem?"		
Seen by a cardiologist			Had an echocardiogram or stress test?		

Explain all "YES" answers: \_\_\_\_\_  
 \_\_\_\_\_

**VISION HISTORY:**

VISION HISTORY	YES	NO
Have you ever had an eye injury?		
Do you wear glasses/contacts now?		
Do you require eyewear to participate?		

**DENTAL HISTORY:**

DENTAL HISTORY	YES	NO
Wear a removable orthodontic appliance?		
Have you ever had a tooth knocked out?		
Do you wear a mouth protector?		

Explain all "YES" answers: \_\_\_\_\_  
 \_\_\_\_\_

Explain all "YES" answers: \_\_\_\_\_  
 \_\_\_\_\_

**HEAT ILLNESS HISTORY:**

HEAT ILLNESS HISTORY	YES	NO
Dehydration		
Heat cramps		
Heat intolerance		
Heat stroke		

**HEARING HISTORY:**

HEARING HISTORY	YES	NO
Had a hearing problem/defect/loss?		
Had recurrent ear infections?		
Worn hearing aids?		

Explain all "YES" answers: \_\_\_\_\_  
 \_\_\_\_\_

Explain all "YES" answers: \_\_\_\_\_  
 \_\_\_\_\_

**WEIGHT HISTORY:**

My playing weight last year was \_\_\_\_\_.  
 My current weight is \_\_\_\_\_.  
 My ideal weight would be \_\_\_\_\_.

HISTORY	YES	NO	HISTORY	YES	NO
Are you unhappy with your current weight?			Have you ever used laxatives or other dietary aids to help you lose weight?		
Have you ever tried to lose weight over an extended period of time?			Have you ever been treated for an eating disorder?		
Have you ever been treated for anemia?			Other (please explain):		

Explain all "YES" answers: \_\_\_\_\_  
 \_\_\_\_\_

**WOMEN:**

Age at first period \_\_\_\_\_ Date of last period \_\_\_\_/\_\_\_\_/\_\_\_\_.

Interval between periods \_\_\_\_\_ Duration of periods \_\_\_\_\_.

Number of periods in the last 6 months \_\_\_\_\_.

I perform monthly breast self-examinations?  Yes  No

Birth control method (brand name if pill) \_\_\_\_\_.

Date of last gynecologic exam \_\_\_\_/\_\_\_\_/\_\_\_\_ OR  Never had a gynecologic exam.

Date of last pap smear \_\_\_\_/\_\_\_\_/\_\_\_\_ OR  Never had a pap smear.

<b>HISTORY</b>	<b>YES</b>	<b>NO</b>	<b>COMMENTS</b>
Are your periods irregular?			
Is flow heavy?			
Is heavy bleeding ever a problem?			
Ever have bleeding between periods?			
Cramps stop you from doing activities?			
Do you have any unusual discharge?			
Any previous pregnancies/births?			
Have frequent urinary tract infections?			
Ever had a blood clot in your veins?			

**Explain all "YES" answers:**

\_\_\_\_\_

\_\_\_\_\_

Have you had or do you currently have any other medical problems/injuries not listed on this form?

\_\_\_\_\_

\_\_\_\_\_

Do you have any medical or health problems you are currently receiving treatment for?

\_\_\_\_\_

\_\_\_\_\_

Is there any reason you are not able to participate in athletics?

\_\_\_\_\_

\_\_\_\_\_

Is there any additional health problems you would prefer to discuss privately with our Team Physicians?

\_\_\_\_\_

\_\_\_\_\_

List any special protective equipment you require or would like to have provided

\_\_\_\_\_

\_\_\_\_\_

The Undersigned, herewith:

- A. Understands she must refrain from practice or play during medical treatment until she is discharged from treatment or given a written permit by the attending physician to resume participation.
- B. Certifies the answers to these questions are correct and true.
- C. Understands her having passed the physician examination does not necessarily mean she is physically qualified to engage in athletics, but only that the examiner did not find any medical reason to disqualify her.
- D. Fully realizes The Columbia College Athletic Department cannot be held responsible for any previous medical condition(s) she might have.

**SIGNATURE OF PARTICIPANT** \_\_\_\_\_ **DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_

**SIGNATURE OF PARENT/GUARDIAN** \_\_\_\_\_ **DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_  
(IF UNDER THE AGE OF 18)

**Please list primary care physician, address, and phone number below:  
(if you do not have a primary care physician, designate NONE)**

Upon completion of the Medical History Form, it is to be reviewed and signed by a Staff Athletic Trainer.

**SIGNATURE OF ATHLETIC TRAINER** \_\_\_\_\_ **DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_