Wheaton College
New Intercollegiate Athlete MEDICAL HISTORY
Please Print

Name: _____ Sport(s): _____ ID#: _____

DOB: _____ Sex: _____ Cell Phone: _____ Age: _____ Year: _____

FEMALES ONLY:

1. Have you ever had a period? Yes/No Age of Onset?
2. How many periods have you had in the past year? ___
3. Interval between periods? _____ Duration of periods? ____
4. Are you on medication for your periods? Yes/No
   If "Yes" name of medication: _____
5. Have you gained or lost more then 10 lbs. in the past year?
6. Are you happy with your weight? Yes/No
   Explain: _____
7. Are you trying to gain or lose weight? Yes/No
8. Has anyone recommended you change your weight or diet? Yes/No
9. Do you limit or carefully control what you eat? Yes/No

CARDIOLOGY QUESTIONS:

10. Have you ever had discomfort, pain, or pressure in your chest during exercise?	Yes/No
11. Does your heart race or skip beats during exercise?	Yes/No
12. Have you ever fainted or passed out during or after exercise?	Yes/No
13. Has a doctor ever ordered a test for your heart? (i.e. EKG, echocardiogram)	Yes/No
14. Has a doctor ever told you that you have:	
High Blood Pressure	Yes/No
High Cholesterol	Yes/No
Heart Murmur	Yes/No
Heart Infection	Yes/No
Abnormal Heart Beat	Yes/No
Sickle Cell Disease	Yes/No
15. Do you have a family history of the following:	
Sudden Death	Yes/No
Death under age 50	Yes/No
Heart Disease	Yes/No
Heart Attack	Yes/No
Passing out/Syncope	Yes/No
Sickle Cell Disease	Yes/No
High Blood Pressure	Yes/No
Marfan's Syndrome	Yes/No

Explain "Yes" answers here (Please number the answer.):

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NEUROLOGICAL QUESTIONS:

16. Have you ever experienced any of the following:	
"Burner" or "Stinger"	Yes/No
Head injury or concussion/ How Many? _____	Yes/No
"Blacked out"/"Knocked out"	Yes/No
Confusion or memory loss due to hit to head	Yes/No
Seizures/Epilepsy	Yes/No
Hospitalization due to a concussion or mild traumatic brain injury	Yes/No
Headaches with exercise	Yes/No
Numbness, tingling, or weakness in your arms or legs after falling or being hit	Yes/No
Inability to move a limb due to a hit or a fall	Yes/No

ORTHOPEDIC QUESTIONS:

17. Have you ever had an injury, illness, or surgery (i.e. sprain, strain, tendonitis, fracture, stress fracture, dislocation, etc.) that caused you to miss a practice or game?	Yes/No
18. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	Yes/No
19. Have you had any fractures or stress fractures in the past two years?	Yes/No

Circle the following body part(s) that apply to the above three questions:

Head	Hand	Wrist	Neck	Chest
Lower Leg	Back	Hip	Ankle	Shoulder
Thigh	Foot/Toes	Arm	Elbow	Knee
Other Organs:				

20. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	Yes/No

GENERAL MEDICAL QUESTIONS:

21. Has a doctor ever denied or restricted your participation in sports for any reason?	Yes/No
22. Do you have or have you had any of the following? If "Yes" please circle.	Yes/No

Cancer	Asthma	Chicken Pox	Diabetes	Heat Illness
Hepatitis	Hernia	Pneumonia	Ulcers	Measles
Mono	High/Low Blood Sugar		Birth Deformities	
Rheumatic Fever		Kidney Disease		Tuberculosis
Shortness of Breathe		Hospitalization		Surgery

23. Are you currently taking any prescription or non-prescription (over-the-counter) medications?	Yes/No
24. Do you have allergies to medicines, pollens, foods, or stinging insects?	Yes/No
25. Are you taking supplements?	Yes/No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	Yes/No
27. Do you or a family member have a history of asthma or exercise induced bronchospasms?	Yes/No
28. Were you born without, missing, or have lost function of an organ (ovary, kidney, eye, testicle, etc.)?	Yes/No
29. Do you have any skin disorders (herpes, cold sores, rashes, acne, eczema)?	Yes/No
30. Have you had any chronic medical problems (chronic fatigue, thyroid condition, diabetes, etc.)?	Yes/No
31. Do you wear glasses or contacts for athletics?	Yes/No
32. Have you had any problems with your vision?	Yes/No
33. Do you regularly use braces, pads, mouth guards, assistive devices, neck rolls, goggles, etc.?	Yes/No
34. Have you ever received Chiropractic care?	Yes/No

Student Athlete's Signature _____ RN Initials _____

Physician's Signature _____ Date: _____ ATC Initials _____