

**Gardner-Webb University Athletic Training
Medical History**

- I. This question is part of your physical examination for participation in college athletics. This is part of your medical record and will be treated confidentially.
- II. Please fill in all blanks to the best of your knowledge. This will be screened by our team physician.
- III. Answer all questions.

What sport? _____ Year at GWU 1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____

Name _____ Date _____

Social Security Number _____ Age _____ Birth Date _____

GWU Campus Box _____ GWU Phone Number _____

Home Address _____

City _____ State _____ Zip _____

Parent or Guardian _____ Phone _____

Parent or Guardian's Address _____

In Case of Injury, Notify _____ Phone _____

Family Doctor _____ Address _____

City _____ State _____ Zip _____

Family History	Age	State of Health If Living	Cause of Death	Age at Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
Sister	_____	_____	_____	_____
Wife	_____	_____	_____	_____
Husband	_____	_____	_____	_____

Who in Your Family Has Had: Goiter _____ Diabetes _____

Cancer _____ Tuberculosis _____ Allergies _____

Asthma _____ Heart Attacks Before at 60 _____

High Blood Pressure _____ Gout _____ Strokes Before Age 60 _____

Mental Disorder _____ Convulsion/Epilepsy _____

Migraine Headache _____

MARITAL HISTORY:
Married _____ Single _____ Children _____

Wife's Address _____ Phone _____

Husband's Address _____ Phone _____

Do Not Write In This Space

HEALTH HISTORY

Please check the correct answer following each question:

A. HEAD INJURY

1. Did you ever have spasms or convulsions as an infant? Yes___ No___
2. Have you ever had a seizure, convulsion fit or epileptic attack? Yes___ No___
3. Have you ever had, or has it been suggested that you should have, a brain wave test (EEG or Electroencephalogram)? Yes___ No___
4. Have you ever had, or has it been suggested that you have, a skull X-Ray or brain scan? Yes___ No___
5. Have you ever been unconscious? If yes, check the following: Yes___ No___
1. Knocked out _____ If yes, how many times _____
2. Passed out fainted, or blacked out _____
3. Were you hospitalized for this? Yes___ No___
- A. Did this occur while participating in athletics? Yes___ No___
- If yes, which sports: _____
- B. How long were you unconscious? Less than 5 minutes _____
- Less than 15 minutes _____ Over 15 minutes _____
- C. Were you seen by a physician? Yes___ No___
- D. Were you admitted to a hospital or infirmary? Yes___ No___
- E. Were X-Rays made? Yes___ No___
- F. Were you given a brain wave test (EEG)? Yes___ No___
- G. How long after being unconscious before you were allowed to participate in athletics again?
- Less than 2 days _____ Less than 1 week _____ Over 1 week _____
6. Have you ever had a skull fracture? Yes___ No___
7. Have you ever had amnesia (loss of memory) following a head injury? Yes___ No___
8. Do you now, or have you ever, suffered from frequent headaches? Yes___ No___
9. Have you ever had blurred or double vision? Yes___ No___
10. Have you ever had a concussion without being unconscious? Yes___ No___
- How many times? _____
- How long to make a complete recovery? _____
- How many games missed following concussion? _____
- When was your last concussion? _____

B. EYES

1. Have you ever been told you had a lazy eye? Yes___ No___
2. Do you have an absence of one eye? Yes___ No___
3. Do you have diminished or abnormal vision? Yes___ No___
4. Do you normally wear glasses? Yes___ No___
5. Do you wear contact lenses? Yes___ No___
- If yes, hard or soft? _____
- Contacts fitted by: _____

Do Not Write In This Space

7. Last seen by doctor for vision check? _____

8. Have you ever had an eye injury? Yes___ No___

9. Have you ever had eye surgery? Yes___ No___

C. EARS

1. Do you have any defect of hearing? Yes___ No___

2. Do you have any drainage? Yes___ No___

3. Do you have any ringing in your ears? Yes___ No___

4. Have you ever had ear injury or ear surgery? Yes___ No___

D. NOSE

1. Do you have frequent nose bleeds? Yes___ No___

2. Have you ever broken your nose? Yes___ No___

3. If broken, did you have surgery? Yes___ No___

4. Have you had difficulty breathing through your nose? Yes___ No___

E. DENTAL AND THROAT

1. Do you have any false teeth or plates? Yes___ No___

2. Have you fractured a tooth? Yes___ No___

3. Have you had a tooth knocked out? Yes___ No___

4. Have you had more than one tooth knocked out? Yes___ No___

5. Did you miss practice because of the injury? Yes___ No___

6. Dentist last seen: Name _____ Month _____ Year _____

7. Wisdom teeth? In _____ Out _____

F. NECK

1. Have you ever had a neck injury? Yes___ No___

2. Have you ever had a fractured neck or spine? Yes___ No___

3. Have you ever sustained a neck injury while playing organized sports? Yes___ No___

4. Did you have numbness, burning, or sharp pain in your arms or hands? Yes___ No___

5. Did you see a physician? Yes___ No___

6. Were X-Rays made? Yes___ No___

7. Were you in a hospital or infirmary? Yes___ No___

8. How long did you miss practice following injury?
Less than 2 days _____ Less than 1 week _____ More than 1 week _____

9. Have you ever had a pinched nerve? Yes___ No___

10. Have you ever worn a "horse collar" because of neck injury? Yes___ No___

11. Did the collar reduce the incidence of neck injury? Yes___ No___

12. Have you ever been taught to "spear" with your head when you tackle and block? Yes___ No___

Do Not Write In This Space

G. MUSCULOSKELETAL

a. Dislocations

1. Have you ever dislocated a joint? Yes___ No___

2. If answer is yes, please check involved area or areas:

Shoulder (L)____ (R)____ Ankle (L)____ (R)____

Knee-cap (Patella) (L)____ (R)____ Finger (L)____ (R)____

Knee (L)____ (R)____ A-C Separation (L)____(R)____

Elbow (L)____(R)____ Collar bone separation from shoulder (L)____(R)____

3. Has the dislocation occurred more than once? Yes___ No___

How many times____ Last occurrence_____

4. Did you see a physician with initial dislocation? Yes___ No___

5. Were X-Rays made? Yes___ No___

6. Was the involved area immobilized (put in cast splint or other immobilization?) Yes___ No___

7. Did you have surgery? Yes___ No___

8. Were you given specific exercises following the injury or surgery? Yes___ No___

b. Spine

1. Have you ever injured your back? Yes___ No___

2. Have you injured your back more than once? Yes___ No___

3. When did you first have back trouble?

Before high school____ During high school____ During college_____

4. Did you see a physician? Yes___ No___

5. Were X-Rays made? Yes___ No___

6. How long did you miss practice?

Less than 2 days____ Less than 1 week____ More than 1 week_____

7. Were you ever told that you have a spinal defect that has been present since birth? Yes___ No___

8. Were you ever instructed in special exercises for your back? Yes___ No___

9. Do you have frequent back pain? Yes___ No___

c. Knee

1. Do you have occasional swelling of the knee? Yes___ No___

Does your knee ever lock up? Yes___ No___

Does your knee ever give away? Yes___ No___

Does your knee feel unstable? Yes___ No___

Does your knee hurt following activity? Yes___ No___

2. Have you had a significant knee injury? (L)____ (R)_____ Yes___ No___

3. When did you first injure your knee?

Before high school____ During high school____ During college_____

4. Did you see a physician? Yes___ No___

5. Did you have X-rays taken? Yes___ No___

Do Not Write In This Space

6. Did you have surgery? Date_____

Yes___ No___

7. Name of surgeon _____

Address of surgeon _____

8. If you had surgery, what was repaired?_____

9. Were you given specific knee exercises following surgery or injury?

Yes___ No___

10. How long did you miss practice?

Less than two days_____Less than one week_____ More than one week_____

11. Have you had significant injuries to both knees?

Yes___ No___

12. Have you had surgery on either knee more than once?

Yes___ No___

13. If you had a knee injury in college, did this represent a re-injury from high school?

Yes___ No___

14. If you had a knee injury in high school, do you think it was properly treated?

Yes___ No___

If no, please explain on a separate sheet of paper.

d. Fractures

1. Have you ever had a broken bone?

Yes___ No___

2. If # 1 was yes, check involved area:

Nose_____ Forearm (R or L)_____ Ribs (R or L)_____

Face_____ Hand (R or L)_____ Leg (R or L)_____

Neck_____ Pelvis_____ Foot (R or L)_____

Back_____ Thigh (R or L)_____ Clavicle (R or L)_____

Skull_____ Arm (R or L)_____ Ankle (R or L)_____

3. Was the fracture a result of organized participation in athletics?

Yes___ No___

What sport?_____

4. Was your athletic performance altered following injury?

Yes___ No___

5. Do you have any residual defect as a result of the fracture?

Yes___ No___

e. Myositis Ossificans Traumatic

1. Have you ever had calcium to form in your thigh or arm following a bad bruise?

Yes___ No___

Right _____ Left _____

2. How much time did you miss from practice?_____

3. Was the calcium surgically removed?

Yes___ No___

4. Do you still have trouble as the result of this injury?

Yes___ No___

f. Muscle Strain

1. Have you ever had a bad "muscle pull" or strain?

Yes___ No___

2. How much time did you miss from practice?

Less than 2 days_____ Less than 1 week_____ More than 1 week_____

3. Did the injury re-occur?

Yes___ No___

4. More than once?

Yes___ No___

5. Did the muscle pull occur initially:

Before high school_____ During high school_____ During college_____

Do Not Write In This Space

g. Ankle Sprain

- 1. Have you ever sprained your ankle? (R)_____ (L)_____ Yes___ No___
- 2. If yes, when did you first sprain your ankle?
Before high school_____ During high school_____ During college_____
- 3. When first sprained, was your ankle taped? Yes___ No___
- 4. Did you see a physician? Yes___ No___
- 5. Was an X-Ray made? Yes___ No___
- 6. Did you have surgery? Yes___ No___
- 7. Did you have any immobilization? Yes___ No___
- 8. Have you had recurrent sprains of the ankle? Yes___ No___
- 9. At present, do you always tape or wrap your ankles? Yes___ No___

h. Foot or Toe Injuries:

- 1. Have you ever had a foot problem? (R)_____ (L)_____ Yes___ No___
- 2. What type of problem?_____
- 3. Did you see a physician? Yes___ No___
Was surgery required? Yes___ No___
- 4. Do you wear arch supports? Yes___ No___
What type:_____
- 5. Have you ever had a toe problem? Yes___ No___
Please describe:_____

H. CARDIAC

Do you have or have you ever had?

- 1. High blood pressure Yes___ No___
- 2. Any disease of the valves of the heart Yes___ No___
- 3. Any congenital heart disease present since birth Yes___ No___
- 4. Abnormal heart rate Yes___ No___
- 5. Palpitation or flutter of heart Yes___ No___
- 6. Heart Murmur Yes___ No___
- 7. Shortness of breath at rest Yes___ No___
- 8. Frequent cough Yes___ No___
- 9. Chest pressure with exertion Yes___ No___

I. GENITOURINARY

- 1. Absence of one kidney Yes___ No___
- 2. Frequent urinary infection Yes___ No___
- 3. Kidney stone Yes___ No___
- 4. Blood in urine Yes___ No___
- 5. Sexually Transmitted Disease Yes___ No___

For Males Only:

- A. Do you have absence of either testicle? Yes___ No___
- B. Is one testicle much smaller than the other? Yes___ No___

For Females Only:

- A. Have you ever had an injury to your breasts? Yes___ No___
- B. Have you ever had surgery on your breasts? Yes___ No___
- C. Have you ever had surgery on the ovaries or uterus (womb)? Yes___ No___
- F. How long do your periods typically last? _____ days
- G. How often do you have a period? Every_____ days
- H. Are your periods painful or do you notice any clotting? Yes___ No___
- I. Do you use any contraceptives (Birth control)? Yes___ No___

Do Not Write In This Space

For Females Only (continued)

D. Do you have both of your ovaries? Yes___ No___

Yes___ No___

J. Do you have any recurrent gynecological infections? Yes___ No___

Yes___ No___

Do Not Write In This Space

E. When was your last menstrual period? _____

J. GASTROINTESTINAL

1. Frequent diarrhea Yes___ No___

6. Liver infection (hepatitis) Yes___ No___

2. Frequent nausea Yes___ No___

7. Jaundice Yes___ No___

3. Frequent constipation Yes___ No___

8. Enlarged spleen Yes___ No___

4. Ulcer disease Yes___ No___

9. Ruptured spleen Yes___ No___

5. Pre-game stress (Nausea, vomiting) Yes___ No___

10. Hernia Yes___ No___

11. Hemorrhoids Yes___ No___

K. SKIN

1. Frequent boils Yes___ No___

4. "Jock itch" Yes___ No___

2. Severe acne Yes___ No___

5. Herpes Yes___ No___

3. Athletes' foot Yes___ No___

L. MISCELLANEOUS DISEASE

1. Diabetes Yes___ No___

9. Hepatitis Yes___ No___

2. Frequent sinus infection Yes___ No___

10. Asthma Yes___ No___

3. Polio Yes___ No___

11. Infectious mononucleosis Yes___ No___

4. Measles Yes___ No___

12. Scarlet fever Yes___ No___

5. Frequent strep throat Yes___ No___

13. Tuberculosis Yes___ No___

6. Seasonal allergy Yes___ No___

14. Epilepsy Yes___ No___

7. Abnormal bruising Yes___ No___

15. Food allergy Yes___ No___

8. Drug allergy Yes___ No___

16. Abnormal bleeding tendency Yes___ No___

List drug(s) _____

17. Sickle Cell Yes___ No___

M. SURGERY

1. Appendectomy Yes___ No___

Other surgery Yes___ No___

2. Tonsillectomy Yes___ No___

If yes what type? _____

3. Hernia repair Yes___ No___

N. HEAT DISORDER

1. Have you ever had trouble with dehydration (excess loss of salt or water)? Yes___ No___

2. Have you ever had heat exhaustion? Yes___ No___

3. Have you ever had a heat stroke? Yes___ No___

4. Were you hospitalized? Yes___ No___

5. How long did you miss practice? Yes___ No___

Less than 2 days___ Less than 1 week___ More than 1 week___

O. IMMUNIZATIONS

1. Have you been immunized against tetanus? month/year _____ Yes___ No___

2. Have you been immunized against the flu? month/year _____ Yes___ No___

3. Have you been immunized against Hepatitis B? month/year _____ Yes___ No___

P. DRUG, FOOD SUPPLEMENTS, AND MISCELLANEOUS AGENTS

Check the appropriate space according to your use of the following items:

	Never	Rarely	Occasionally	Frequently
1. Vitamin	_____	_____	_____	_____
2. Wheat Germ	_____	_____	_____	_____
3. Bone Meal	_____	_____	_____	_____
4. Stimulants (Benzedrine, amphetamine)	_____	_____	_____	_____
5. Cigarettes	_____	_____	_____	_____
6. Sleeping pills	_____	_____	_____	_____
7. Alcoholic Beverages	_____	_____	_____	_____
8. Anabolic agents (Growth stimulants or hormones)	_____	_____	_____	_____
9. Weight loss products	_____	_____	_____	_____
10. Nutritional supplements	_____	_____	_____	_____

If #10 is yes, what supplements? _____

Q. TRAINING AND CONDITIONING

Check appropriate space which most clearly resembles your own training and conditioning program:

1. LENGTH OF TRAINING

Some form of training year-round Yes___ No___ Training 6 months per year Yes___ No___
 Training 4 months per year Yes___ No___ Training 9 months per year Yes___ No___

2. TRAINING TERMS

Weight lifting Yes___ No___ Specific exercises for knees Yes___ No___
 Isometrics Yes___ No___ Specific exercises for back Yes___ No___
 Nautilus Yes___ No___ Reaction training Yes___ No___
 Flexibility exercises Yes___ No___ Endurance training Yes___ No___
 Specific exercises for shoulders Yes___ No___

R. MENTAL FITNESS

1. Have you ever been treated for:

A) psychosis (hearing voices) Yes___ No___ C) anorexia or bulimia Yes___ No___
 B) depression or attempted suicide Yes___ No___ D) drug/ alcohol addiction Yes___ No___

2. Are you currently on medications for any mental illness? Yes___ No___

If yes, please list medications: _____

3. Do you see any possibility of any need for counseling in the future? Yes___ No___

S. Miscellaneous

1. Do you currently have any condition which would affect your participation in athletics at Gardner-Webb University? If yes, please explain: _____

To the best of my knowledge the answers to the questions in this questionnaire are true.

Signature _____ Date _____

Do Not Write In This Space