Dear AU Tiger and Parents,

Welcome to Auburn University! We are glad to have you join the Auburn "family". We would like to ask that you review and complete the enclosed forms listed on the checklist below.

1. Medical History - This will let us know about any previous medical problems and hopefully prevent any further problems.

2. Demographics - This form includes athletes name, age, birth date, social security number and their Auburn address and phone number.

3. Assumption of Risk - By signing this form, you understand the injury risks that are associated with athletic participation. This form is required by both the NCAA and Auburn University.

4. Medical Release - This will allow us to receive copies of medical records for any previous injuries/illnesses.

5. Insurance Information/Beneficiary Designation - The cover letter explains our athletic accident policy which provides insurance for injuries sustained while participating in the play/practice of intercollegiate sports.

6. Front and back copy of insurance card(s) and policy holder's driver's license. Also copy of student athlete's photo ID.

7. Nutrition, Concussion, Dental, and Vision Questionnaires.

8. All doctor's notes, x-ray, MRI and bone scan reports, and any other pertinent information on orthopedic injuries occurring within the last 5 years. These must be attained from the physician and mailed or faxed directly to the Sports Medicine staff. This is the responsibility of the athlete or athlete's parents to attain.

Please be sure to use **Adobe Acrobat** application to open this document to Fill,Sign and attach supporting document images. Upon completion please use the secure link (https://auburn.app.box.com/f/c864e03c14de48239f49057db635bfbe) to upload your document.
We must have these completed forms on file before you will be allowed to get a physical and practice with your team.

Once again, welcome to the Auburn "family", and we look forward to meeting you this fall.

Sincerely,

Joe-Joe Petrone, MS, ATC/L
Director of Sports Medicine

AUBURN UNIVERSITY ATHLETIC DEPARTMENT
MEDICAL HISTORY QUESTIONNAIRE

NAME:_____ SPORT:_____

SOCIAL SECURITY #:_____ SEX: Pick One BIRTHDATE:_____

Please check any/all of the following that you have, have had, or are now undergoing treatment for:

- ☐ ADD/ADHD
- ☐ Allergies (Drugs, food, insects)
- ☐ Anemia
- ☐ Appendicitis
- ☐ Asthma
- ☐ Bladder Illness/Injury
- ☐ Bleeding Tendencies
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Eating Disorders
- ☐ Emotional Disturbance (Depression/Anxiety)
- ☐ Exercise Induced Asthma
- ☐ Frequent/Severe Headaches
- ☐ Fainting/Passing out
- ☐ Head Injury/ Concussion
- ☐ Hearing Defect
- ☐ Heart Disease (Marfan's Syndrome, Hypertension, etc)
- ☐ Heat Illness (Cramps, Heat Exhaustion, etc.)
- ☐ Hepatitis
- ☐ Hernia
- ☐ Hiatal Hernia
- ☐ High/Low Blood Pressure
- ☐ Kidney Disease/Injury
- ☐ Learning Disability
- ☐ Liver Disease/Injury
- ☐ Measles
- ☐ Menstrual Disorder
- ☐ Mental Illness
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Narcolepsy
- ☐ Palpitation/Pounding Heart
- ☐ Pneumonia
- ☐ Sickle Cell Trait/ Anemia
- ☐ Spastic Colon/Irritable Bowel Syndrome
- ☐ Spleen Illness/Injury
- ☐ Stomach Trouble
- ☐ Stress Fracture
- ☐ Tuberculosis
- ☐ Tumors, Growths, Cysts, Cancer, etc.
- ☐ Thyroid Disorder
- ☐ Ulcers

GENERAL

1. Do you have full use of both eyes? Y ◯ N ◯
2. Do you wear contacts? Y ◯ N ◯
   If yes, what type? Hard ☐ Soft ☐ Disposable ☐ Brand Name:_____
   Eye Doctor's Name:_____
   Address: _____
   Phone #: _____
3. Do you wear glasses? Y ◯ N ◯
   Eye Doctor's Name:_____
   Address: _____
   Phone #: _____
4. Do you wear dentures, partials, false teeth, retainers, etc.? Y ◯ N ◯
   Explain:_____
5. Did you miss any games or practice because of injury during high school/junior college? Y ◯ N ◯

GENERAL cont.

6. Have you ever been told you should wear a brace, use tape, etc.? Y ◯ N ◯
   What body part?_____
   Why?_____
7. Have you ever been told you can not take part in any sport? Y ◯ N ◯
   Explain:_____
8. Do you have any other medical problems not mentioned above? Y ◯ N ◯
   If yes, what problems?_____
9. Have you ever been told to have a test or surgery that you did not elect to do? Y ◯ N ◯
   Explain:_____
10. Have you ever been involved in a Motor Vehicle Accident and suffered injuries which required medical attention? Y ◯ N ◯
    If yes, give date(s): _____
    Describe injuries: _____
11. Have you ever passed out while exercising? Y ◯ N ◯
12. Have you ever passed out for any reason? Y ◯ N ◯
13. Do you frequently cough after exercise? Y ◯ N ◯
14. Have you ever had chest pain while exercising? Y ◯ N ◯
15. Have you ever seen a cardiologist, pulmonologist, or neurologist? Y ◯ N ◯
    If yes, who and why? _____
    Doctor's Name: _____
    Address: _____
    Phone #:_____
16. Have you ever been told you have a heart murmur? Y ◯ N ◯
17. Did you have an EKG or Echo? Y ◯ N ◯
    If yes, give Date(s):_____
    Doctor's Name:_____
    Address/Phone #:_____
18. Has anyone in your family died before the age of 50 or suddenly? Y ◯ N ◯
    If so, who and how did it happen:_____
19. Does any disease run in your family, i.e. Diabetes, Heart Disease, etc.? Y ◯ N ◯
    If yes, which disease(s)?_____
20. Have you ever been told you have an eating disorder? Y ◯ N ◯
    If yes, what did you have?_____
    Did you get treatment? Y ◯ N ◯ Were you admitted to the hospital? Y ◯ N ◯
    If yes, give Date(s):_____
    Doctor's Name:_____
    Address/Phone #:_____

GENERAL cont.

21. Have you ever been told you have ADD or ADHD? Y ◯ N ◯
    Do you take medication? Y ◯ N ◯ If so, what?_____
22. Have you ever had an ADD/ADHD workup? Y ◯ N ◯
    If yes, give Date(s):_____
    Doctor's Name:_____
    Address/Phone #:_____
    _____
23. Have you ever been told you have Lupus? Y ◯ N ◯
24. Have you ever been told you have Fibromyalgia? Y ◯ N ◯
25. Have you ever been told you have arthritis? Y ◯ N ◯
26. Do you have any pins, screws, or other implants? Y ◯ N ◯
    If yes, where are they?_____
27. Are you allergic to any medications? Y ◯ N ◯
    If yes, what medication(s)?_____
28. Are you allergic to any substance, i.e. insects, stings, pollen, foods, etc.? Y ◯ N ◯
    If yes, which substance(s)?_____
29. Are you intolerant to anything, i.e. lactose, gluten, fructose, etc? Y ◯ N ◯
    If yes, what?_____
30. Are you now taking any medications, i.e. Anti-Depressants, Ritalin, etc.? Y ◯ N ◯
    If yes, which medication(s)?_____
31. Have you been told to take a medication which you no longer take? Y ◯ N ◯
    If yes, which medication(s)?_____
32. Are you now taking any supplements, i.e. Creatine, Vitamins, etc.? Y ◯ N ◯
    If yes, which supplement(s)?_____
33. Are you or have you ever used anabolic steroids or a growth hormone? Y ◯ N ◯
34. Have you ever had a positive drug test? Y ◯ N ◯
    If yes, what was it positive for?_____
35. Have you ever played at or attended another college, university or Jr. college? Y ◯ N ◯
    If yes, what school(s)?_____
36. Have you ever not passed a physical at another school? Y ◯ N ◯

HEAD

1. Have you ever had a concussion? Y ◯ N ◯
   If yes, how many times? _____ How much practice/game time was lost? _____
   Give date(s): _____
2. Have you ever been knocked unconscious? Y ◯ N ◯
   If yes, give date(s):_____
   How long were you knocked out?_____
   Describe how it occurred:_____
   _____

HEAD cont.

3. Have you ever been knocked unconscious more than once? Y ◯ N ◯
   If yes, explain:_____
   _____
4. Did you see a physician for any of the above 3 questions? Y ◯ N ◯
   If yes, give Date(s):_____
   Doctor's Name:_____
   Address/Phone #:_____
   _____
5. Was a CT scan or MRI taken? Y ◯ N ◯
6. Do you have frequent headaches? Y ◯ N ◯
7. Have you ever been told you have migraine headaches? Y ◯ N ◯
   If yes, Medication(s) taken:_____
   Doctor's Name:_____
   Address/Phone #:_____
   _____
8. Do you have difficulty with your eyes during or after competition? Y ◯ N ◯
   If yes, explain:_____
9. Have you ever had a seizure? Y ◯ N ◯
10. Did you see a physician for any of the above problem(s)? Y ◯ N ◯
    If yes, give Date(s):_____
    Doctor's Name:_____
    Address/Phone #:_____
    _____

NECK

1. Have you ever sustained neck pain (stinger, pinched nerve, etc.)? Y ◯ N ◯
2. Did you have numbness, burning, or sharp pain in your arms and hands? Y ◯ N ◯
   If yes, give date(s):_____
3. Have you ever had numbness in both arms at the same time? Y ◯ N ◯
4. Have you ever worn a collar because of a neck injury? Y ◯ N ◯
5. Did you see a physician for any of the above problem(s)? Y ◯ N ◯
   If yes, give Date(s):_____
   Doctor's Name:_____
   Address/Phone #:_____
   _____
6. Were x-rays, CAT scan, or MRI done? Y ◯ N ◯
7. Were you admitted to a hospital or infirmary? Y ◯ N ◯
   If yes, give Date(s):_____
8. How much practice/game time was missed:_____

NECK cont.

9. Have you ever seen a PT or athletic trainer or receive rehab for your neck? Y ◯ N ◯
   If yes, how long?_____
   Name of place/ phone #: _____
10. Have you ever seen a chiropractor/massage therapist for your neck? Y ◯ N ◯

BACK

1. Have you ever injured your back? Y ◯ N ◯
2. Have you ever injured your back more than once? Y ◯ N ◯
   If yes, give dates:_____
3. Were you ever told that you have a congenital spinal defect? Y ◯ N ◯
4. Were you ever told that you have spondyloliothesis/spondylolysis? Y ◯ N ◯
5. Were you ever told that you have a bulging or herniated disc? Y ◯ N ◯
6. Have you had a low back muscle strain? Y ◯ N ◯
7. Have you had a high back muscle strain? Y ◯ N ◯
   If "6" or "7" is yes, describe how and when this occurred:_____
   _____
8. Do you have frequent backaches? Y ◯ N ◯
9. Have you ever had associated leg pain or pain that ran down your leg? Y ◯ N ◯
   Explain:_____
10. Did you see a physician, or chiropractor for any of the above problem(s)?
    If yes, give Date(s):_____
    Doctor's Name:_____
    Address/Phone #:_____
    _____
11. Were x-rays, CAT scan, or MRI made? Y ◯ N ◯
12. How much practice/game time was missed:_____
    _____
13. Have you ever seen a PT or athletic trainer or receive rehab for your back? Y ◯ N ◯
    If yes, how long?_____
    Name of place/phone #:_____
14. Have you ever seen a chiropractor/massage therapist for your back? Y ◯ N ◯

SHOULDER

1. Have you had a shoulder injury? Y ◯ N ◯
   R ☐ L ☐ Date(s)_____
2. Was it a throwing type injury? Y ◯ N ◯
   If "yes", explain:_____
   _____
3. Was it an injury caused by contact? Y ◯ N ◯
   If "yes", explain:_____

SHOULDER cont.

4. If questions "2" and "3" were "no," then how did you injury your shoulder?

_____

_____

5. Has your shoulder ever "come out of place" or dislocated? Y ◯ N ◯
   R ☐ L ☐ Date(s)_____
6. Did you see a physician? Y ◯ N ◯
   If yes, give Date(s):_____
   Doctor's Name:_____
   Address/Phone #:_____

   _____
7. Were X-rays, CT Scan, MRI, Arthrogram made? Y ◯ N ◯
8. Did you have surgery? Y ◯ N ◯
   If yes, give Date(s):_____
   Doctor's Name:_____
   Address/Phone #:_____

   _____

   Describe the surgery(s):_____

   _____
9. How much practice/game time was lost?_____
10. Have you ever seen a PT or athletic trainer or receive rehab for your shoulder? Y ◯ N ◯
    If yes, how long?_____
    Name of place/phone #:_____
11. Describe any difficulty you may have now:_____

    _____

ELBOW

1. Have you ever injured either elbow? Y ◯ N ◯
   R ☐ L ☐ Date(s)_____
2. Did you see a physician? Y ◯ N ◯
   If yes, give Date(s):_____
   Doctor's Name:_____
   Address/Phone #:_____

   _____
3. Were X-rays, CAT scan, MRI made? Y ◯ N ◯
4. Were you put in a cast or immobilized? Y ◯ N ◯
5. Did you have surgery? Y ◯ N ◯
   If yes, give Date(s):_____
   Doctor's Name:_____
   Address/Phone #:_____

   _____

ELBOW cont.

Describe the surgery(s):_____

_____

6. How much practice/game time was lost?_____
7. Did you see a PT or athletic trainer or receive rehab for your elbow? Y ◯ N ◯
   If yes, how long?_____
   Name of place/phone #:_____
8. Describe any difficulty you may have now:_____

_____

WRIST

1. Have you ever injured either wrist? Y ◯ N ◯
   R ☐ L ☐ Date(s)_____
2. Have you ever had a TFCC injury? Y ◯ N ◯
3. Have you ever been told or diagnosed with carpal tunnel syndrome? Y ◯ N ◯
4. Did you see a physician for any of the above? Y ◯ N ◯
   If yes, give Date(s):_____
   Doctor's Name:_____
   Address/Phone #:_____

   _____
5. Were X-rays, CAT scan, MRI made? Y ◯ N ◯
6. Were you put in a cast or immobilized? Y ◯ N ◯
7. Did you have surgery? Y ◯ N ◯
   If yes, give Date(s):_____
   Doctor's Name:_____
   Address/Phone #:_____

   _____

   Describe the surgery(s):_____

   _____
8. How much practice/game time was lost?_____
9. Did you see a PT or athletic trainer or receive rehab for your wrist? Y ◯ N ◯
   If yes, how long?_____
   Name of place/phone #:_____
10. Describe any difficulty you may have now:_____

    _____

HIP/THIGH

1. Have you ever had a significant hip or thigh injury? Y ◯ N ◯
   R ☐ L ☐ Date(s)_____
2. Have you ever had any clicking or popping in your hip? Y ◯ N ◯

HIP/THIGH cont.

3. Did you see a physician? Y ◯ N ◯
   If yes, give Date(s):_____
   Doctor's Name:_____
   Address/Phone #:_____
4. Were x-rays, CAT scan, MRI made? Y ◯ N ◯
5. Were you put in a cast or immobilized? Y ◯ N ◯
6. Did you have surgery? Y ◯ N ◯
   If yes, give Date(s):_____
   Doctor's Name:_____
   Address/Phone #:_____
   Describe the surgery(s):_____
7. How much practice/game time was lost?_____
8. Did you see a PT or athletic trainer or receive rehab for your hip/thigh? Y ◯ N ◯
   If yes, how long?_____
   Name of place/phone #:_____
9. Describe any difficulty you may have now:_____

KNEE

1. Have you ever had a significant knee injury? Y ◯ N ◯
   R☐ L☐ Date(s)_____
2. Did you see a physician? Y ◯ N ◯
   If yes, give Date(s):_____
   Doctor's Name:_____
   Address/Phone #:_____
3. Were x-rays, CAT scan, MRI made? Y ◯ N ◯
4. Were you put in a cast or immobilized? Y ◯ N ◯
5. Did you have surgery? Y ◯ N ◯
   If yes, give Date(s):_____
   Doctor's Name:_____
   Address/Phone #:_____
   Describe the surgery(s):_____
6. Were you given specific knee exercises following surgery or injury? Y ◯ N ◯
7. How much practice/game time was missed?_____

KNEE cont.

8. Did you see a PT or athletic trainer or receive rehab for your knee? Y ◯ N ◯
   If yes, how long?_____
   Name of place/phone #:_____
9. Have you had surgery on either knee more than once? Y ◯ N ◯
   R☐ L☐ Date(s)_____
10. Have you ever had chronic problems with your knee? Y ◯ N ◯
    IT Band R☐ L☐ Date(s)_____
    Patellar tendon R☐ L☐ Date(s)_____
    Chondromalacia R☐ L☐ Date(s)_____
    Patellar Femoral Pain R☐ L☐ Date(s)_____
    Bursitis R☐ L☐ Date(s)_____
    Osgood-Schlatters R☐ L☐ Date(s)_____
11. Does your knee ever collect fluid or swell during or after activity? Y ◯ N ◯
    R☐ L☐ Date(s)_____
12. Does your knee lock? Y ◯ N ◯
    R☐ L☐ Date(s)_____
13. Does your knee give way? Y ◯ N ◯
    R☐ L☐ Date(s)_____
14. Does your knee feel unstable? Y ◯ N ◯
    R☐ L☐ Date(s)_____
15. Does your knee hurt after activity? Y ◯ N ◯
    R☐ L☐ Date(s)_____

ANKLE

1. Have you ever had a significant ankle injury? Y ◯ N ◯
   R☐ L☐ Date(s)_____
2. Have you ever sprained your ankle(s)? Y ◯ N ◯
   R☐ L☐ Date(s)_____
3. Have you ever had a high ankle/syndesmotic sprain? Y ◯ N ◯
   R☐ L☐ Date(s)_____
4. Did you see a physician? Y ◯ N ◯
   If yes, give Date(s):_____
   Doctor's Name:_____
   Address/Phone #:_____
   _____
5. Were X-rays, Cat Scans, MRI made? Y ◯ N ◯
6. Did you have surgery? Y ◯ N ◯
   If yes, give Date(s):_____
   Doctor's Name:_____
   Address/Phone #:_____

ANKLE cont.

Describe the surgery(s):_____

_____

7. Did you have a cast or immobilizer? Y ◯ N ◯
   R☐ L☐ Date(s)_____
   If "yes", for how long?_____
8. Have you had recurrent ankle sprains? Y ◯ N ◯
   R☐ L☐ Date(s)_____
9. Did you see a PT or athletic trainer or receive rehab for your ankle? Y ◯ N ◯
   If yes, how long?_____
   Name of place/phone #:_____

FEET/TOES

1. Have you ever had a significant injury to your foot or toes? Y ◯ N ◯
   R☐ L☐ Date(s)_____
2. Did you see a physician? Y ◯ N ◯
   If yes, give Date(s):_____
   Doctor's Name:_____
   Address/Phone #:_____

   _____
3. Were X-rays, Cat Scans, MRI made? Y ◯ N ◯
4. Did you have surgery? Y ◯ N ◯
   If yes, give Date(s):_____
   Doctor's Name:_____
   Address/Phone #:_____

   _____
5. Have you ever had plantar fasciitis? Y ◯ N ◯
   R☐ L☐ Date(s)_____
6. Have you ever had shin splints? Y ◯ N ◯
   R☐ L☐ Date(s)_____
7. Have you ever been told you have flat feet or high arches? Y ◯ N ◯
   R☐ L☐ Date(s)_____
8. Have you ever had "turf toe?" Y ◯ N ◯
   R☐ L☐ Date(s)_____
9. Have you ever used orthotics? Y ◯ N ◯
   R☐ L☐ Date(s)_____
10. Did you see a PT or athletic trainer or receive rehab for your feet/toes? Y ◯ N ◯
    If yes, how long?_____
    Name of place/phone #:_____

DISLOCATIONS

1. Have you ever dislocated a joint? Y ◯ N ◯
2. If answer to "1" was "yes", please check involved area and list how many times dislocated:

Shoulder	☐	R ☐	L ☐	Date(s)_____
Ankle	☐	R ☐	L ☐	Date(s)_____
Patella	☐	R ☐	L ☐	Date(s)_____
Knee	☐	R ☐	L ☐	Date(s)_____
A/C Separation	☐	R ☐	L ☐	Date(s)_____
Thumb	☐	R ☐	L ☐	Date(s)_____
Index Finger	☐	R ☐	L ☐	Date(s)_____
Middle Finger	☐	R ☐	L ☐	Date(s)_____
Ring Finger	☐	R ☐	L ☐	Date(s)_____
Little Finger	☐	R ☐	L ☐	Date(s)_____
Big Toe	☐	R ☐	L ☐	Date(s)_____
Little Toes	☐	R ☐	L ☐	Date(s)_____
Hip	☐	R ☐	L ☐	Date(s)_____

3. If answer to "1" was "yes," has the dislocation occurred more than once? Y ◯ N ◯
4. Did it "go back in"/reduce without intervention? Y ◯ N ◯
5. Did it "go back in"/reduce without intervention? Y ◯ N ◯
6. Did you see a physician? Y ◯ N ◯

   If yes, give Date(s):_____

   Doctor's Name:_____

   Address/Phone #:_____

   _____

7. Were x-rays taken? Y ◯ N ◯
8. Was the involved area immobilized? Y ◯ N ◯
9. Did you have surgery? Y ◯ N ◯

   If yes, give Date(s):_____

   Doctor's Name:_____

   Address/Phone #:_____

   _____

   Describe the surgery(s):_____

   _____

10. Did you see a PT or athletic trainer or receive rehab for your dislocation? Y ◯ N ◯

    If yes, how long?_____

    Name of place/phone #:_____

FRACTURES

1. Have you ever broken a bone? Y ◯ N ◯
2. If "1" was "yes", check the involved area(s):

1. Nose	☐	Date(s)_____	2. Skull	☐	Date(s)_____
3. Neck	☐	Date(s)_____	4. Face	☐	Date(s)_____
5. Arm	☐	R☐ L☐	Date(s)_____		
6. Forearm	☐	R☐ L☐	Date(s)_____		
7. Ribs	☐	R☐ L☐	Date(s)_____		
8. Hand	☐	R☐ L☐	Date(s)_____		
9. Finger	☐	R☐ L☐	Date(s)_____		
10. Wrist	☐	R☐ L☐	Date(s)_____		
11. Pelvis	☐	R☐ L☐	Date(s)_____		
12. Thigh	☐	R☐ L☐	Date(s)_____		
13. Lower Leg	☐	R☐ L☐	Date(s)_____		
14. Foot	☐	R☐ L☐	Date(s)_____		
15. Collarbone	☐	R☐ L☐	Date(s)_____		
16. Toes	☐	R☐ L☐	Date(s)_____		
17. Hip	☐	R☐ L☐	Date(s)_____		

3. If "1" was "yes", describe the fracture and how it occurred:_____

_____

_____

4. If "1" was "yes", was your athletic performance altered following the injury? Y ◯ N ◯
5. If "1" was "yes", do you have residual defects as a result of a fracture? Y ◯ N ◯
6. Was there a development of a bone spur? Y ◯ N ◯
7. Did you see a physician? Y ◯ N ◯

   If yes, give Date(s):_____

   Doctor's Name:_____

   Address/Phone #:_____

   _____

8. Did you have surgery? Y ◯ N ◯

   If yes, give Date(s):_____

   Doctor's Name:_____

   Address/Phone #:_____

   _____

   Describe the surgery(s):_____

   _____

9. Did you see a PT or athletic trainer or receive rehab for your fracture? Y ◯ N ◯

   If yes, how long?_____

   Name of place/phone #:_____

MUSCLE INJURIES

1. Have you ever had a "bad" muscle pull or strain? Y ◯ N ◯
   If yes, list which muscle(s) and date(s) of injuries:_____
2. How much time was lost from practice/games?_____
3. Did the injury reoccur? Y ◯ N ◯
   If yes, explain and give date(s) of re-injury:_____
4. Did you see a physician? Y ◯ N ◯
   If yes, give Date(s):_____
   Doctor's Name:_____
   Address/Phone #:_____
5. Did you have surgery? Y ◯ N ◯
   If yes, give Date(s):_____
   Doctor's Name:_____
   Address/Phone #:_____
   Describe the surgery(s):_____
6. Did you see a PT or athletic trainer or receive rehab for your muscle injury? Y ◯ N ◯
   If yes, how long?_____
   Name of place/phone #:_____

MYOSITIS OSSIFICATIONS

1. Have you ever had a calcium deposit form in your thigh or arm following a bad bruise or muscle strain? Y ◯ N ◯
   Thigh ☐ R ☐ L ☐ Date(s)_____
   Arm ☐ R ☐ L ☐ Date(s)_____
2. How much practice/game time was missed?_____
3. Do you currently still have the calcium deposit in your thigh or arm? Y ◯ N ◯
4. Were x-rays taken? Y ◯ N ◯
5. Did you see a physician? Y ◯ N ◯
   If yes, give Date(s):_____
   Doctor's Name:_____
   Address/Phone #:_____

MYOSITIS OSSIFICATIONS cont.

6. Did you have surgery? Y ◯ N ◯

   If yes, give Date(s):_____

   Doctor's Name:_____

   Address/Phone #:_____

   _____

   Describe the surgery(s):_____

   _____

MISCELLANEOUS

1. Have you ever lost a paired organ (i.e. kidney, eye, testicle)? Y ◯ N ◯
2. Have you ever had a cortisone injection/shot? Y ◯ N ◯

   If yes, please describe where and why:_____

   _____

3. Have you ever had a PRP injection (platelet rich plasma)? Y ◯ N ◯

   If yes, for what purpose?_____

   _____

4. List and describe any other injuries/illnesses that you have sustained, giving dates for all and explaining in detail their occurrence, and any current medical problems:

   _____

   _____

   _____

I hereby state that, to the best of my knowledge, all of the information in this questionnaire is correct and accurate. I understand that my failure to report medical history accurately could result in a delay or denial of my clearance for athletic participation or could result in harm to my body.

Student-Athlete's Signature	Date
Parent's Signature (if student-athlete is under 19)	Date

I, _____, do hereby grant my permission to Auburn University Athletic Department, the Athletic Training Staff, and Physicians employed by them, and any other medical professional deemed necessary, to treat any athletic injury I might incur during my athletic career, according to the policies and procedures of the NCAA and the Auburn University Athletic Department.

Student-Athlete's Signature	Date
Parent's Signature (if student-athlete is under 19)	Date

Auburn University Athletic Department

Informed Consent, Assumption of Risks Voluntary Waiver, Release of Liability & Hold Harmless

ATHLETE INFORMATION

Name of Athlete:_____

Address: _____ **City:**_____ **State:**_____ **Zip:**_____

Phone Number:_____ **Date of Birth:**_____ **Gender:** M◯ F◯

SPORT (Please list all sports you participate in at Auburn University)

_____

Time/Date(s) (Academic Years) :

Informed Consent, Assumption of Risks Voluntary Waiver, Release of Liability & Hold Harmless

PLEASE READ THIS DOCUMENT (HEREAFTER "AGREEMENT") CAREFULLY BEFORE SIGNING. THIS IS A LEGALLY BINDING DOCUMENT. THIS COMPLETED AND SIGNED AGREEMENT MUST BE SUBMITTED BEFORE ANY PERSON IS ALLOWED TO PARTICIPATE IN THE ABOVE SPORT AT AUBURN UNIVERSITY.

I, the undersigned, wish to participate in the above acknowledged sport (hereafter "Sport") during the time/date(s) as indicated above and, in consideration for my participation, I hereby agree as follows:

1. **Assumption of Risks and Informed Consent**

I acknowledge, understand and appreciate that as part of my participation in this Sport there are dangers, hazards and inherent risks to which I may be exposed. I recognize that the Sport and its activities involve risk of injury and I agree to accept any and all risks associated with it, including but not limited to: serious physical injury; temporary or permanent disability; death; serious neck and spinal injuries that may result in complete or partial paralysis; brain damage; serious injury to virtually all internal organs; serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system; and serious injury or impairment to other aspects of the body, general health, and well-being. I understand the danger and risk of participating in the program may not only result in serious injury, but in economic and property loss; serious impairment of future abilities to earn a living; to engage in other business, social, and recreational activities; and generally to enjoy life. Furthermore, I recognize that participation in the program involves activities and risk of injury incidental thereto, including but not limited to, the correct or incorrect performance of playing techniques in tryouts, practices, warm-ups, games, drills, exercises, scrimmages, plays, matches, and other similar undertakings; physical contact with other participants, bystanders, the playing surface, training equipment, goalposts, and other objects in and around the field; training room procedures; the use of training equipment; the administration of first aid; the failure to follow game, training, safety or other team rules; the use of playing techniques taught and/or teaching methods employed by Auburn University coaches and staff members, even if those techniques are taught and employed correctly; or the use of transportation provided or arranged by Auburn University to and from practices, games and other related activities. The dangers, hazards and risks may arise from my own actions, inactions, or negligence as well as from the actions, inactions or negligence of others, or the condition of the premises. I also acknowledge and understand that there may be other dangers, hazards or risks not presently known or reasonably foreseeable.

I understand that protective equipment, no matter how well designed and maintained, cannot guarantee the prevention of bodily injury or death, as acknowledged in the above paragraph. I also recognize that no helmet, brace, padding or other protective equipment can absolutely prevent possible head, neck or other potentially serious injuries that are sustained while playing or practicing the Sport. I understand the risk of injury from using poorly fitting, worn or defective protective equipment, or from the use or misuse of protective equipment to deliberately injure an opponent player. I understand and agree to follow all safety precautions required for participation.

Therefore, I voluntarily accept and assume all risk of injury, loss of life or damage to property arising out of training, preparing, participating and traveling to or from this Sport.

2. Voluntary Waiver of Claims, Release of Liability and Hold Harmless

In consideration of my participation in the Sport and to the fullest extent permitted by law, I agree to release, Auburn University, its trustees, officers, directors, employees, agents , volunteers and assigns (hereafter "Auburn") from and against all claims arising out of or resulting from my training, preparing, participating and/or travelling to and from the Sport. "Claim" as used in this agreement means any financial loss, claim, suit, action, damage, or expense, including but not limited to: attorney's fees, bodily injury, sickness, disease or death, or injury to or destruction of tangible property including loss of use resulting therefrom**. I furthermore agree to release, defend, indemnify and hold harmless Auburn from and against any and all liability, actions, debts, claims and demands of every kind whatsoever, specifically including, but not limited to, any claim for negligence or negligent acts or omissions and any present or future claim, loss or liability for injury to person or property that I may suffer, for which I may be liable to any other person, that may or does arise out of my participation in the Sport.** This agreement is binding on my heirs and assigns and includes all claims, both present and future, that may be made by me, my family, estate, heirs or assigns.

3. Reporting of Injuries & Authorization for Medical Care

I accept responsibility for reporting injuries and illnesses in a timely fashion to the Auburn University Medical /Auburn Athletic Training staff, including signs and symptoms of concussions / head injuries, and heat illnesses / exertional sickling.

In the event of an accident or serious illness, I hereby authorize representatives of Auburn to obtain medical treatment for me. I hereby hold harmless and agree to indemnify Auburn from any claims, causes of action, damages and/or liabilities, arising out of or resulting from said medical treatment.

4. Choice of Law

This AGREEMENT shall be governed by and construed under the laws of Alabama. I agree that any legal action or proceeding relating to this AGREEMENT, or arising out of any injury, death, damage or loss as a result of my participation in any part of the Sport, shall be brought only in Lee County, Alabama.

I, the undersigned have been given ample time to read and understand this AGREEMENT, and fully accept its contents and conditions and agree to them by signing this AGREEMENT voluntarily. I understand that I am giving up substantial rights (including my right to sue), and acknowledge that I am signing this document freely and voluntarily, and intend by my signature to provide a complete and unconditional release of all liability to the greatest extent allowed by law. My signature on this document is intended to bind not only myself but also my successors, heirs, representatives, administrators, and assigns. The information I have provided is disclosed accurately and truthfully.

A PARENT OR GUARDIAN MUST SIGN THIS FORM FOR A MINOR UNDER THE AGE OF 19

Print Athlete's Full Name:_____

Athlete's Signature:_____ Date:_____

ACKNOWLEDGEMENT BY PARENT OR LEGAL GUARDIAN

As parent(s) of the Student named above, I acknowledge that I am aware of the participation of our son/daughter in the Sport as indicated above. I further acknowledge and accept the terms of this AGREEMENT. **I HAVE READ THE AGREMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT MY CHILD AND I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.**

Print Full Name of Parent/Legal Guardian:_____

Signature of Parent/Legal Guardian:_____ Date:_____

Print Full Name of Parent/Legal Guardian:_____

Signature of Parent/Legal Guardian:_____ Date:_____

ATHLETE DEMOGRAPHIC INFORMATION

Please Print Clearly!

NAME:_____
LAST FIRST MIDDLE SPORT

SOCIAL SECURITY/ID#:_____ BIRTHDATE (MM/DD/YYYY):_____

ALLERGIES:_____

LOCAL ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

LOCAL PHONE #:_____ CELL PHONE #:_____

PERMANENT ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

PERMANENT PHONE #:_____

BANNER ID #:_____ AUBURN EMAIL:_____

EMERGENCY CONTACT (IN USA):

NAME:_____

RELATIONSHIP:_____ EMAIL:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME PHONE #:_____ WORK PHONE #:_____

CELL PHONE #:_____

FATHER/GUARDIAN:_____

SOCIAL SECURITY/ID#:_____ BIRTHDATE (MM/DD/YYYY):_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME PHONE #:_____ WORK PHONE #:_____

CELL PHONE #:_____ EMAIL:_____

MOTHER/GUARDIAN:_____

SOCIAL SECURITY/ID#:_____ BIRTHDATE (MM/DD/YYYY):_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME PHONE #:_____ WORK PHONE #:_____

CELL PHONE #:_____ EMAIL:_____

MEDICAL RELEASE

TO: All Universities, Colleges, High Schools, Physicians, Athletic Trainers, Registered Dietician, Hospitals, Clinics, Dispensaries, Sanatoriums and all other agencies.

FROM: Auburn University Sports Medicine Department
Office of the Team Physician
349 S. Donahue Drive
Auburn, AL 36849
Phone: 334-844-9821
Fax: 334-844-8139

RE: _____
(Student-Athlete)

SOCIAL SECURITY/ID #:_____ BIRTHDATE:_____

You are hereby authorized and requested to send Auburn University Sports Medicine Department: Attention Michael Goodlett, MD, a complete copy of all your records pertaining to my medical condition, including all physicals, athletic trainer's records, any diagnosis, treatment, history, prognosis of any and all injuries together with all other information pertaining to my past or present medical condition, diagnosis, treatment, history, prognosis, from your personal knowledge and/or records.

A copy of this authorization shall be considered as effective and valid as the original.

_____ _____
Student-Athlete Signature Date

_____ _____
Witness Signature Date

INSURANCE INFORMATION

Dear Parent or Guardian:

I hope this letter finds you well as the end of the school year and summer are approaching. We are pleased to have your son/daughter as a student athlete in our Auburn University Athletic Program and want to take care of your child as best as possible while he/she is here at Auburn.

Our policy states that any athletic medical claim will be billed to the parents' insurance as a primary provider (per NCAA compliance) with Auburn University Athletics covering any remaining balances that are not covered, partially paid, denied or applied to your deductible for athletic sustained injuries/illnesses. If an athletic claim is filed through your insurance, like all claims, you will receive a Statement of Billing/ Explanation of Benefits. This is for your records. If you or your son/daughter receive any type of billing or check from your insurance company for medical services originating from your son/daughter's participation at Auburn University, you should forward these bills/checks to:

Joe-Joe Petrone, ATC
Auburn University Sports Medicine Department
PO Box 351
Auburn, AL 36831-0351

(334) 844-9823-OFFICE
(334) 844-8704-FAX
jap0017@auburn.edu

To assist us in providing medical coverage for your son/daughter, please fill out and return the accompanying forms. If you do not have insurance, or your insurance does not cover your son/daughter, please fill out and sign the form accordingly. All non-scholarship athletes MUST have a 12 month healthcare insurance policy that covers athletic injuries (such as Cigna, Aetna, BCBS, Tricare, etc). This cannot be a life insurance policy. If your insurance does cover your son/daughter, please complete the form and return with a copy of the front and back of your insurance card(s) and a copy of the photo ID of the policy holder as well as photo ID of your son/daughter. If you have any questions about this please feel free to call.

Thank you for your cooperation in this matter.

Sincerely,

Joe-Joe Petrone, MS, ATC/L
Director of Sports Medicine
(334) 844-9823

ATHLETE INSURANCE INFORMATION

If you have any questions regarding this form contact:
Karen Straub-Stanton, MS, ATC
Auburn University Sports Medicine
349 S. Donahue Fax #: (334)844-8139
Auburn, AL 36849 Phone #: (334)844-9722

Please Print Clearly!

DATE:_____

ATHLETE:_____ BIRTHDATE (MM/DD/YYYY)_____

SOCIAL SECURITY/ID #:_____ SPORT:_____

BANNER ID #:_____

PRIMARY MEDICAL INSURANCE

INSURANCE COMPANY NAME:_____

INSURANCE CO CLAIMS ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____ PHONE:_____

POLICY/ID #:_____ GROUP #:_____

EFFECTIVE DATE:_____

HMO:☐ PPO:☐ TRICARE/CHAMPUS☐ OTHER☐

POLICY EXEMPTIONS or REQUIREMENTS:_____

PRECERTIFICATION REQUIRED? YES◯ NO◯ IF YES, PLEASE EXPLAIN:_____

_____

PRECERTIFICATION PHONE #:_____

INFORMATION ON POLICY HOLDER (THE ONE WHO PAYS THE PREMIUM):

NAME:_____

RELATIONSHIP TO ATHLETE:_____

SOCIAL SECURITY/ID #:_____ BIRTHDATE (MM/DD/YYYY):_____

ADDRESS:_____ CITY:_____ STATE/ZIP:_____

PRIMARY EMAIL ADDRESS:_____

HOME PHONE #:_____ CELL PHONE #:_____

EMPLOYED BY:_____ WORK PHONE #:_____

EMPLOYER ADDRESS:_____ (CITY/STATE/ZIP):_____

*****PLEASE ATTACH LEDGIBLE FRONT AND BACK COPY OF THIS INSURANCE CARD, AS WELL AS A COPY OF POLICY HOLDER'S PHOTO ID*****

SECONDARY INSURANCE (MEDICAL, DENTAL, or PHARMACY)

INSURANCE COMPANY NAME:_____

INSURANCE CO CLAIMS ADDRESS:_____

CITY:_____STATE:_____ZIP:_____PHONE:_____

POLICY/ID #:_____GROUP #:_____

POLICY EXEMPTIONS or REQUIREMENTS:_____

PRECERTIFICATION REQUIRED? YES◯ NO◯ IF YES, PLEASE EXPLAIN:_____

_____

PRECERTIFICATION PHONE #:_____

INFORMATION ON POLICY HOLDER (THE ONE WHO PAYS THE PREMIUM):

NAME:_____

RELATIONSHIP TO ATHLETE:_____

SOCIAL SECURITY/ID #:_____BIRTHDATE (MM/DD/YYYY):_____

ADDRESS:_____CITY:_____STATE/ZIP:_____

PRIMARY EMAIL ADDRESS:_____

HOME PHONE #:_____ CELL PHONE #:_____

EMPLOYED BY:_____ WORK PHONE #:_____

EMPLOYER ADDRESS:_____(CITY/STATE/ZIP):_____

*****PLEASE ATTACH LEDGIBLE FRONT AND BACK COPY OF THIS INSURANCE CARD, AS WELL AS A COPY OF POLICY HOLDER'S PHOTO ID****

I certify that all the above information is correct. If any incorrect or incomplete information has been given, then I am responsible for the payment of charges. _____ (Initials)

I authorize Auburn University Athletic Department to file claim in my behalf for all claims classified as "Athletic". I understand that I am responsible for payments of all charges incurred for claims classified as "Non-athletic" or "Pre-existing" injuries. _____ (Initials)

THE FOLLOWING AUTHORIZATION MUST BE SIGNED BEFORE AUBURN UNIVERSITY CAN COVER ANY MEDICAL EXPENSES INCURRED BY THIS ATHLETE:

_____Thereby authorize the Auburn University Athletic Department to file a claim on my behalf for the athletic injury/illness sustained by _____(dependent) under the above group medical policy. Further, I agree and consent that any amounts payable under this policy be paid to the medical provider or Auburn University Athletic Department as shown below.

_____My son/daughter is not covered under my personal health insurance.

I, the undersigned, do hereby agree and give my consent for the Auburn University Athletic Department or its designates to furnish medical care and treatment to my son/daughter as considered necessary and proper in diagnosing or treating their physical and mental condition. Further, I hereby authorize Auburn University Athletic Department and its representatives to inspect or secure copies of case history, laboratory reports, diagnosis, x-rays, and any other data in relation to this medical claim. This authorization may be photocopied and any photocopies should be deemed as valid and applicable to the original.

_____ _____

Signature of Policy Holder Date

_____ _____

Signature of Athlete Date

AUBURN UNIVERSITY SPORTS MEDICINE
INSURANCE INFORMATION

Please upload the front and back of your insurance card.

Front	Back

Please upload the policy holder's Photo ID.

Photo ID

Please upload the student athlete's Photo ID.

BENEFICIARY DESIGNATION

As an insured intercollegiate student-athlete enrolled in Auburn University, the Auburn University Athletic Department is pleased to provide you with NCAA Catastrophic Injury coverage. Under this coverage, as an insured student-athlete you are provided with accidental death benefits while participating in intercollegiate athletics at Auburn University.

The purpose of this beneficiary designation is to provide you your right under the policy to designate a beneficiary to whom any death benefit shall be payable and, at your option, the beneficiary designation may be changed by you at any time.

DESIGNATION OF BENEFICIARY

If I, _____, do not name a beneficiary or if my named beneficiary does not survive me, I understand that the payment of any benefits will be made to my estate, or at the option of the underwriting company, to the following:

a) My spouse, if living; otherwise
b) My then living children, if any; otherwise
c) My surviving parent(s); otherwise
d) My surviving brothers and/or sisters, equally.

I name as beneficiary(ies) the person(s) named below:

_____ _____
Name of Beneficiary Relationship

_____ _____
Name of Beneficiary Relationship

EXECUTED this _____ day of _____, 20_____.

_____ _____
Signature of Student-Athlete Date

_____ _____
Signature of Student-Athlete's Parent or Guardian Date

AUBURN SPORTS MEDICINE
NUTRITIONAL SUPPLEMENT WAIVER

I will not take any nutritional supplement* other than those provided by Auburn Athletics without written approval of Carly Fancher, Sports Dietitian or Dr. Michael Goodlett, Head Team Physician. I understand that nobody can guarantee that a supplement is 100% pure. If I decide to take a supplement, I understand that it is at my own risk.

**Nutritional supplement*: anyproduct (pill, tablet, powder, liquid, beverage,etc.) designedtosupplement thediet and includingoneor moreof thefollowingingredients: vitamins, minerals, herbs or botanicals, aminoacids, calorieboosters, or a concentrate, metabolite, constituent, extract, or combinationof theseingredients.

Signed:_____

Printedname:_____

Date:_____

Athletes who wish to take supplements purchased on their own should bring these supplements to their initial nutrition consultation.

ALL supplements you are taking must be approved by Lauren Silvio or Dr. Michael Goodlett (even if you have used them in the past).

Please list below which supplements you are currently taking or have taken in the past 3 months:

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

Student Athlete Nutrition Screening Tool

Name_____Sport _____ Date_____Cell:_____

Please answer as completely as possible:

1. **I participate in additional physical activity ≥20 minutes in length on days that I have practice or competition.**
   - ◯ Frequently ◯ Sometimes
   - ◯ Rarely ◯ Never

KEY:

Exercise =	Physical activity ≥ 20 minutes
Practice =	Scheduled time allotted by coach to work as a team or individually in order to improve performance
Training =	Intense physical activity. The goal is to improve fitness level in order to perform optimally.

2. **If I cannot exercise, I find myself worrying that I will gain weight.**
   - ◯ Frequently ◯ Sometimes
   - ◯ Rarely ◯ Never

3. **I believe that most athletes have some form of unhealthy/disordered eating habits.**
   - ◯ Strongly agree ◯ Agree
   - ◯ Disagree ◯ Strongly disagree

4. **During training, I control my fat and calorie intake carefully.**
   - ◯ Frequently ◯ Sometimes
   - ◯ Rarely ◯ Never

5. **I do not eat foods that have more than 3 grams of fat.**
   - ◯ Strongly agree ◯ Agree
   - ◯ Disagree ◯ Strongly disagree

6. **My performance would improve if I lose weight.**
   - ◯ Strongly agree ◯ Agree
   - ◯ Disagree ◯ Strongly disagree

7. **If I got on the scale tomorrow and gained 2 pounds, I would practice or exercise harder or longer than usual.**
   - ◯ Frequently ◯ Sometimes
   - ◯ Rarely ◯ Never

8. **I weigh myself:**
   - ◯ Daily ◯ 2 or more times a week
   - ◯ Weekly ◯ Monthly or less

9. **If I know that I will be consuming alcoholic beverages, I will skip meals on that day or the following day.**
   - ◯ Frequently ◯ Sometimes
   - ◯ Rarely ◯ Never

10. **I feel guilty if I choose fried foods for a meal.**
    - ◯ Frequently ◯ Sometimes
    - ◯ Rarely ◯ Never

11. **If I were to be injured, I would still exercise even if I was instructed not to do so by my athletic trainer or physician.**
    - ◯ Strongly agree ◯ Agree
    - ◯ Disagree ◯ Strongly disagree

12. **I take dietary or herbal supplements in order to increase my metabolism and/or to assist in burning fat.**
    - ◯ Frequently ◯ Sometimes
    - ◯ Rarely ◯ Never

13. **I am concerned about my percent body fat.**
    - ◯ Frequently ◯ Sometimes
    - ◯ Rarely ◯ Never

14. **Being an athlete, I am very conscious about consuming adequate calories and nutrients on a daily basis.**
    - ◯ Frequently ◯ Sometimes
    - ◯ Rarely ◯ Never

15. **I am worried that if I were to gain weight, my performance would decrease.**
    - ◯ Strongly agree ◯ Agree
    - ◯ Disagree ◯ Strongly disagree

16. **I think that being thin is associated with winning**.
    - ◯ Strongly agree ◯ Agree
    - ◯ Disagree ◯ Strongly disagree

17. **I train intensely for my sport so I will not gain weight.**
    - ◯ Frequently ◯ Sometimes
    - ◯ Rarely ◯ Never

18. **During season, I choose to exercise on my one day off from practice or competition.**
    - ◯ Frequently ◯ Sometimes
    - ◯ Rarely ◯ Never

19. I feel uncomfortable eating around others.
- Frequently
- Sometimes
- Rarely
- Never

20. I limit the amount of carbohydrates that I eat.
- Frequently
- Sometimes
- Rarely
- Never

21. I try to lose weight to please others.
- Frequently
- Sometimes
- Rarely
- Never

22. If I were unable to compete in my sport, I would not feel good about myself.
- Strongly agree
- Agree
- Disagree
- Strongly disagree

23. If I were injured and unable to exercise, I would restrict my calorie intake.
- Strongly agree
- Agree
- Disagree
- Strongly disagree

24. In the past 2 years I have been unable to compete due to an injury.
- 7 or more times
- 4 to 6 times
- 1 to 3 times
- No significant injuries

25. During practice I have trouble concentrating due to feelings of guilt about what I have eaten that day.
- Frequently
- Sometimes
- Rarely
- Never

26. I feel that I have a lot of good qualities.
- Strongly agree
- Agree
- Disagree
- Strongly disagree

27. At times I feel that I am no good at all.
- Strongly agree
- Agree
- Disagree
- Strongly disagree

28. I strive for perfection in all aspects of my life.
- Strongly agree
- Agree
- Disagree
- Strongly disagree

29. I avoid eating meat in order to stay thin.
- Strongly agree
- Agree
- Disagree
- Strongly disagree

30. I am happy with my present weight.
- Yes
- No

31. I have done things to keep my weight down that I believe are unhealthy.
- Frequently
- Sometimes
- Rarely
- Never

32. **I eat much less than others eat.**
- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

33. I feel like I am in control when I am fasting or restricting food intake.
- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

34. I almost never eat anything without estimating how many calories I am eating.
- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

35. I think that being too thin is not as bad as being too fat.
- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

36. I get lightheaded or weak from not eating or restricting my food.
- Frequently
- Sometimes
- Rarely
- Never

37. I am almost always on a diet.
- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

38. I eat when I am not hungry.
- Frequently
- Sometimes
- Rarely
- Never

39. I sometimes eat much more than others eat.
- Strongly agree
- Agree
- Disagree
- Strongly Disagree

40. I use food to numb difficult feelings.
- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

41. I am obsessive in the way I think about food.
- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

42. I avoid eating when I am hungry.
- ◯ Frequently
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

43. I find myself preoccupied with food.
- ◯ Frequently
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

44. I have gone on eating binges where I feel that I may not be able to stop.
- ◯ Frequently
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

45. I cut my food into small pieces.
- ◯ Frequently
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

46. I try to avoid food with a high carbohydrate content (bread, rice, potatoes, etc.).
- ◯ Frequently
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

47. I feel that others would prefer if I ate more.
- ◯ Strongly agree
- ◯ Agree
- ◯ Disagree
- ◯ Strongly disagree

48. I vomit after I have eaten.
- ◯ Frequently
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

49. I feel extremely guilty after eating.
- ◯ Frequently
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

50. **I think about burning up calories when I exercise**.
- ◯ Frequently
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

51. Other people think that I am too thin.
- ◯ Strongly Agree
- ◯ Agree
- ◯ Disagree
- ◯ Strongly Disagree

52. I am preoccupied with the thought of having fat on my body.
- ◯ Strongly agree
- ◯ Agree
- ◯ Disagree
- ◯ Strongly Disagree

53. I avoid foods with sugar in them.
- ◯ Frequently
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

54. I feel that food controls my life.
- ◯ Strongly Agree
- ◯ Agree
- ◯ Disagree
- ◯ Strongly Disagree

55. I display self-control around food.
- ◯ Strongly Agree
- ◯ Agree
- ◯ Disagree
- ◯ Strongly Disagree

56. I feel that others pressure me to eat.
- ◯ Frequently
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

57. I give too much time and thought to food.
- ◯ Strongly Agree
- ◯ Agree
- ◯ Disagree
- ◯ Strongly Disagree

58. I feel uncomfortable after eating sweets.
- ◯ Frequently
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

59. I enjoy trying new, rich foods.
- ◯ Frequently
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

60. I avoid foods with gluten in them.
- ◯ Frequently
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

Auburn University Sports Medicine

Concussion/Sickle Cell History Sheet

What is a concussion?
A concussion is a disturbance in brain function caused by a direct or indirect force to the head. It results in a variety of non-specific symptoms (like those listed below) and often does not involve loss of consciousness. Concussion should be suspected in the presence of **any one or more** of the following:

- Symptoms (such as headache), or
- Physical signs (such as unsteadiness), or
- Impaired brain function (e.g. confusion) or
- Abnormal behavior

Playing with a concussion can result in significant long and short term adverse side effects.
It is of extreme importance to know <u>your</u> individual concussion/head injury history!

Have you ever been told that you had a concussion? Yes ◯ No ◯
If so how many? Dates:

Did you have loss of conscience with a concussion? Yes ◯ No ◯

Did you have amnesia with a concussion? Yes ◯ No ◯

How long were you held from practice or play with a concussion?_____
Was the concussion sports related? Yes ◯ No ◯

Practice or game? _____

Did you have a CT/MRI? Yes ◯ No ◯
Did you see a neurologist? Yes ◯ No ◯
Did you have long term academic side effects? Yes ◯ No ◯
Did you have recurrent headaches after the concussion? Yes ◯ No ◯
Have you ever been removed from practice or games to be evaluated for a concussion? Yes ◯ No ◯
Do you know your sickle cell trait status? Yes ◯ No ◯
Does anyone in your family have sickle cell disease or trait? Yes ◯ No ◯
Have you ever had a heat illness requiring hospitalization? Yes ◯ No ◯

_____ _____

Athlete signature Date Parent or guardian signature Date

AUBURN UNIVERSITY SPORTS MEDICINE CARDIOVASCULAR HISTORY FORM

NAME:_____ DATE OF EXAM:_____

SPORT:_____ BANNER ID #:_____ DATE OF BIRTH:_____

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	◯	◯
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
2. Have you ever passed out or nearly passed out DURING or AFTER exercise?	◯	◯
3. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	◯	◯
4. Does your heart ever race or skip beats (irregular beats) during exercise?	◯	◯
5. Has a doctor ever told you that you have any heart problems? Check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____	◯	◯
6. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)	◯	◯
7. Do you get lightheaded or feel more short of breath than expected during exercise?	◯	◯
8. Have you ever had an unexplained seizure?	◯	◯
9. Do you get more tired or short of breath more quickly than your friends during exercise?	◯	◯
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
10. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?	◯	◯
11. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?	◯	◯
12. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	◯	◯
13. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	◯	◯

*By signing I certify that the answers to the questions above are correct and true.

_____ _____

Signature of Athlete Date

Modified from PPE-4 Form

Dental Health Care Questionnaire

Name:_____ Sport:_____

1. Have you ever had any type of dental or mouth problem? Yes_____No_____

If yes, please explain:_____

_____

2. Do you wear a mouthpiece while you play sports? Yes_____No_____

3. Have you ever been told that you have a TMJ problem? Yes_____No_____

If yes, please explain:_____

_____

4. When was your last dental visit? Pick one

5. If you have dental appliances, when is your next visit or adjustment_____

6. Have you ever been told to have some dental care that you have not yet completed? Y N

If yes, please explain:_____

_____

7. Have you ever been told to remove your wisdom teeth? Yes_____No_____

8. Do you have dental pain now when you:

Sleep: Yes_____No_____
Eat: Yes_____No_____
Chew gum or other things: Yes_____No_____

9. Do you need to see a dentist for any reason? Yes_____No_____

If yes, please explain:_____

_____

4/2010

Visual Health Care Questionnaire

Name:_____ Sport:_____

1. Have you ever had any eye injury or visual problem? Yes_____No_____

If yes, please explain:_____

_____

2. When was your last visit to your eye doctor? Pick One

Please give name and phone # of your specialist:_____

_____

3. Do you currently wear corrections (glasses or contacts)? Yes_____No_____

If yes, which? Contacts_____Glasses_____ Brand_____

Prescription: R_____ L _____

4. Do you have a copy of the prescription for correction in Auburn? Yes_____No_____

5. Have you ever been told to get glasses or contacts? Yes_____No_____

6. Do you have trouble seeing in class? Yes_____No_____

7. Do you have or get frequent headaches? Yes_____No_____

If so, when you get them, are they related to a particular activity? Please explain:_____

_____

8. Do you need to see an eye specialist for any reason? Yes_____No_____

If yes, please explain:_____

_____

4/2010