DATE_____

UNIVERSITY OF CINCINNATI
INITIAL ATHLETIC HEALTH APPRAISAL

(Place your name and date at the top of each page and then answer all questions in each section.)

NAME:_____ SOCIAL SECURITY #_____
SPORT:_____ AGE:____ CLASS: FROSH:____ SOPH:____ JR:____ 5-SR:____

MEDICAL HISTORY

Do you now have or have you ever had any of the following:
(Be sure to check the last column if a current problem.)

	YES	NO	CHECK IF A CURRENT PROBLEM
Rheumatic Fever	___	___	___
Asthma	___	___	___
Depression, Anxiety or other nervous disorder	___	___	___
Breathing Difficulty with Exercise	___	___	___
Cough with Exercise	___	___	___
Pneumonia	___	___	___
Mononucleosis	___	___	___
Heart Murmur/Problem	___	___	___
High Blood Pressure	___	___	___
High Cholesterol	___	___	___
Heart Infection	___	___	___
Has a doctor ever ordered any tests for your heart?	___	___	
Diabetes	___	___	___
Epilepsy/Convulsion/Seizure	___	___	___
Recurrent Headaches	___	___	___
Concussion	___	___	___
Confusion from an injury	___	___	___
Loss of memory from an injury	___	___	___
Bleeding Tendency	___	___	___
Sickle Cell Trait/Disease	___	___	___
Stroke or Blood Clot	___	___	___
Immune System Disease	___	___	___
Heat-related Illness/Problem	___	___	___
Anorexia or Bulimia	___	___	___
Kidney Disease	___	___	___
Stomach Disorder	___	___	___
Hernia	___	___	___
Allergy	___	___	___
Seasonal	___	___	___
Food	___	___	___
Insect stings or bites	___	___	___

continued

DATE_____

NAME_____

Continued from Page 1

	YES	NO	CHECK IF A CURRENT PROBLEM
Skin Disorder	___	___	___
Rashes	___	___	___
Herpes	___	___	___
Appendicitis	___	___	___
Other Surgery	___	___	___
Lightheadedness, Chest Pain, Unexplained Shortness of Breath during exercise	___	___	___
Lightheadedness, Chest Pain, Unexplained Shortness of Breath after exercise	___	___	___
Fainting During Exercise	___	___	___
Fainting After Exercise	___	___	___
Do you tire more quickly than your teammates during exercise?	___	___	___
Do you have excessive fatigue?	___	___	___
Does your heart race or skip a beat during exercise?	___	___	___
Other Medical Problems	___	___	___

Explain:

_____

_____

FAMILY HISTORY

Have any of the following conditions been present in your immediate family (PARENTS OR SIBLINGS)?

	YES	NO	WHO
Asthma	___	___	_____
Heart Conditions	___	___	_____
High Blood Pressure	___	___	_____
Sickle Cell Anemia	___	___	_____
Other Abnormal Hemoglobin	___	___	_____
Died while Exercising	___	___	_____
Died for no apparent reason	___	___	_____
Died suddenly before the age of 50	___	___	_____
Marfan's Syndrome	___	___	_____
Stroke or Blood Clot	___	___	_____

DENTAL HISTORY

Do you have any of the following dental problems?

	YES	NO
Chipped Teeth	___	___
Loose Teeth	___	___
Missing Teeth	___	___
Dental Appliances	___	___

Other: _____

DATE_____
NAME_____

VISUAL HISTORY

	YES	NO
Do you wear glasses during sports participation?	___	___
Do you wear contacts during sports participation?	___	___
Do you wear protective goggles or face shield?	___	___
Do you have any other problems with your eyes or vision?	___	___

WOMEN ONLY:

Do you experience menstrual cramps that interfere with your sport? YES ___ NO ___
When was your first menstrual period? _____
When was your last menstrual period? _____
What was the longest time between your periods in the last year? _____
How many periods have you had in the last 12 months? _____
Other: _____

MEN ONLY: Have you suffered an injury in your genital/groin area?
YES ___ NO ___ A current problem: _____
Other: _____

INJURY HISTORY: Do you now have or have you ever had an injury or problem that was severe enough to require you to see a doctor or miss any part of a game or practice in the areas listed below?

1. ANKLE (Sprain, Fracture, Instability, Tendonitis, Surgery, Other)
   NO ___ (If no, go to #2)
   YES___
   Left ___ Date_____
   Right___ Date_____
   Describe_____
   _____
   Is this a current or persistent problem? No___ Yes___

2. FOOT (Sprain, Fracture, Plantar Fascitis, Surgery, Other)
   NO ___ (If no, go to #3)
   YES___
   Left ___ Date_____
   Right___ Date_____
   Describe_____
   _____
   Is this a current or persistent problem? No___ Yes___

Injury History Continued on Next Page

DATE_____
NAME_____

Continued from Page 3

3. LEG (Fracture, Shin Pain, Surgery, Other)
   NO ___ (If no, go to #4)
   YES___
   Left ___ Date_____
   Right___ Date_____
   Describe_____
   _____
   Is this a current or persistent problem? No___ Yes___

4. KNEE (Sprain, Cartilage, Patellar Pain, Bursitis, Tendonitis, Surgery, Other)
   NO ___ (If no, go to #5)
   YES___
   Left ___ Date_____
   Right___ Date_____
   Describe_____
   _____
   Is this a current or persistent problem? No___ Yes___

5. THIGH (Fracture, Quadriceps Strain, Hamstring Strain, Calcium Deposit, Surgery, Other)
   NO ___ (If no, go to #6)
   YES___
   Left ___ Date_____
   Right___ Date_____
   Describe_____
   _____
   Is this a current or persistent problem? No___ Yes___

6. HIP (Fracture, Muscle Pull, Surgery, Other)
   NO ___ (If no, go to #7)
   YES___
   Left ___ Date_____
   Right___ Date_____
   Describe_____
   _____
   Is this a current or persistent problem? No___ Yes___

7. LOW BACK (Strain, Chronic Pain, Herniated Disc, Surgery, Other)
   NO ___ (If no, go to #8)
   YES___
   Left ___ Date_____
   Right___ Date_____
   Describe_____
   _____
   Is this a current or persistent problem? No___ Yes___

Injury History Continued on Next Page

DATE_____
NAME_____

Continued from Page 4

8. SHOULDER (Dislocation, Separation, Rotator Cuff Injury, Tendonitis, Surgery, Other)
NO ___ (If no, go to #9)
YES___
Left ___ Date_____
Right___ Date_____
Describe_____
_____
Is this a current or persistent problem? No___ Yes___

9. ELBOW (Hyperextension, Dislocation, Tendonitis, Fracture, Surgery, Other)
NO ___ (If no, go to # l0)
YES___
Left __ Date_____
Right__ Date_____
Describe_____
_____
Is this a current or persistent problem? No___ Yes___

l0. FOREARM/UPPER ARM (Fracture, Muscle Pull, Surgery, Other)
NO ___ (If no, go to #11)
YES___
Left ___ Date_____
Right___ Date_____
Describe_____
_____
Is this a current or persistent problem? No___ Yes___

11. WRIST (Sprain, Fracture, Surgery, Other)
NO ___ (If no, go to #12)
YES___
Left ___ Date_____
Right___ Date_____
Describe_____
_____
Is this a current or persistent problem? No___ Yes___

12. HAND/FINGERS (Sprain, Fracture, Persistent Deformity, Dislocation, Surgery, Other)
NO ___ (If no, go to #13)
YES___
Left ___ Date_____
Right___ Date_____
Describe_____
_____
Is this a current or persistent problem No___ Yes___

Injury History Continued on Next Page

DATE_____
NAME_____

Continued from Page 5

13. NECK (Strain, Fracture, Stinger/Burner- numbness, tingling or weakness after being hit or falling, inability to move a part of your body after being hit, Surgery, Other)
NO ___ (If no, go to #l4)
YES___
Left ___ Date_____
Right___ Date_____
Describe_____
_____
Is this a current or persistent problem? No___ Yes___

14. HEAD (Concussion, Unconscious, Surgery, Hospitalized, Other)
NO ___ (If no, go to #15)
YES___
Left ___ Date_____
Right___ Date_____
Describe_____
_____
Is this a current or persistent problem? No___ Yes___

15. FACE (Fracture, Eye Injury, Ear Problem, Fractured Nose, Deviated Septum, Other)
NO ___ (If no, go to #16)
YES___
Left ___ Date_____
Right___ Date_____
Describe_____
_____
Is this a current or persistent problem? No___ Yes___

16. List any other significant injuries, overnight stays in the hospital or surgeries not listed above:
_____
_____
_____
_____
_____

DATE_____
NAME_____

	YES	NO
1. Are you happy with your weight?	___	___
2. Do you have any concerns that you would like to discuss with a doctor?	___	___
3 Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	___	___
4. During the past 30 days have you smoked?	___	___
5. During the past 30 days have you used street or illegal drugs?	___	___
6. During the past 30 days, did you use chewing tobacco, snuff, or dip?	___	___
7. Do you drink regularly?	___	___

Please list and explain any other condition that has not been covered:

_____

_____

	YES	NO
1. Are you presently taking any medication?	___	___
2. Do you have an allergy to any drug?	___	___
3. Is any doctor presently treating you for any disorder?	___	___
4. Do you regularly wear any type of a brace or support or tape for play?	___	___
5. Has a doctor restricted your participation in any sport permanently for any reason?	___	___
6. Do you currently have any type of screw, pin or plate in your body?	___	___
7 Have you had any illness or injury that has not been listed on this questionnaire?	___	___
8. Have you had chicken pox? If yes, at what age _____	___	___
9. Do you take any supplements, drugs, or steroids to help you gain/lose weight or improve your performance?	___	___
10. Do you feel that you are physically fit enough to participate in your sport?	___	___
11. Do you know of, or do you believe there is, any health reason why you should not participate in the University of Cincinnati intercollegiate athletic program at this time?	___	___

THE UNDERSIGNED ATHLETE,

A. Understands that s/he must refrain from practice or play while ill or injured, whether or not receiving medical treatment, and during medical treatment until s/he is discharged from treatment or is given permission by a University of Cincinnati Team Physician to restart participation despite continuing treatment.

B. Understands that having passed the physical examination does not necessarily mean that s/he is physically qualified to engage in athletics, but only that the evaluator did not find a medical reason to disqualify her/him at the time of said examination.

C. Certifies that the answers to the questions on pages 1 through 7 are correct and true.

ATHLETE'S
SIGNATURE: _____

DATE: _____