UNIVERSITY HEALTH SERVICE
830 SOUTH LIMESTONE STREET
LEXINGTON, KY 40536-0582

ATHLETIC HISTORY FORM

Name _____ Student ID # _____ Date _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

Do you have any allergies? □ Yes □ No □ Medicines □ Pollens □ Food □ Stinging Insects
If yes, please identify specific allergy:

Explain "Yes" answers below. CIRCLE questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify: □ Asthma □ Anemia □ Diabetes □ Infections □ Other:		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out during or after exercise?		
6. Have you ever had pain, discomfort, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip bests (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: □ High blood pressure □ Kawasaki disease □ High cholesterol □ A heart murmur □ Other (list): □ A heart infection		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. 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?		
14. 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?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrilator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion? How Many?_____		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses? (list)		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	**Yes**	**No**
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, cast, or crutches?		
20. Have you ever had a sress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

Explain "Yes" answers here: _____

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HABITS (Please fill in the blanks):

Do you use tobacco?_____ How much? _____For how long? _____When stopped? _____ Do you drink alcoholic beverages? _____ How many drinks per week? _____ Other drug use: _____ Do you have any difficulty sleeping? _____Do you think you get enough sleep? _____ Do you use vitamins/supplements/holistic medicines? _____If so, please list_____

FAMILY HISTORY (If any blood relative has had any of the following, please check):

☐ Alcoholism	☐ Bleeds easily	☐ Epilepsy	☐ Mental illness/depression
☐ Anemia	☐ Cancer	☐ Headaches/migraines	☐ Stroke
☐ Arthritis	☐ Diabetes	☐ Heart disease	☐ Thyroid disease
☐ Asthma	☐ Drug addiction	☐ High blood pressure	☐ Unknown Other: _____

Please read carefully and select ALL which apply to you:

☐ Abnormal mole/skin cancer	☐ Alcoholism/substance abuse
☐ Allergies	☐ Anorexia/bulimia
☐ Anxiety	☐ Arthritis
☐ Asthma/wheezing	☐ Attention deficit disorder (ADD or ADHD)
☐ Blood clot or clotting disorder	☐ Bone fractures
☐ Cancer	☐ Chicken pox
☐ Concussion/head injury	☐ Crohn's/colitis
☐ Depression	☐ DES exposure in utero
☐ Diabetes	☐ Drug use
☐ Eczema	☐ GERD
☐ Gout/arthritis	☐ Headaches
☐ Heart disease	☐ Heart murmur
☐ Hepatitis or liver disease	☐ High blood pressure (hypertension)
☐ Infectious mononucleosis (Mono)	☐ Irritable bowel syndrome
☐ Kidney problems	☐ Meningitis
☐ Obesity	☐ Other _____
☐ Pneumonia	☐ Positive TB skin test
☐ Possibility of pregnancy	☐ Seizure disorder
☐ Breastfeeding at this time	☐ Sprains
☐ Stomach ulcers	☐ Stroke
☐ Thyroid problems	☐ Tuberculosis
☐ Victim of physical/sexual violence	

I hereby state that my answers to these questions are correct to the best of my knowledge.

Signature of athlete _____Date _____

Signature of parent/guardian _____Date_____