Stony Brook University Sports Medicine Department
Returning Student-Athlete Medical Questionnaire

Name: _____Sport: _____

SBU ID#: _____ Class (please circle): So Jr Sr 5th

Cell phone #: (____) _____ Campus phone #: _____

Please answer all the questions below: (All information is within the <u>past 12 months)</u>

please use the back of this form for any additional information

1. <u>Injury/ Illness:</u>

Have you had any injury/illness/surgery? __yes __no

Have you been hospitalized? __yes __no

*If you answered **YES** to any of the above, please list conditions and dates:*

1. _____Date:_____
2. _____Date:_____
3. _____Date:_____

2. <u>Allergies/Medical Conditions:</u>

Allergies to insect bites/stings? *Please list*:_____ __yes __no

Allergies to drugs/medications? *Please list:* _____ __yes __no

Food Allergies? *Please list*:_____ __yes __no

Do you carry an Epi-Pen? *Allergy?*_____ __yes __no

Are you Diabetic? *Type?*_____*How is it controlled?* _____ __yes __no

Asthma/Exercise-Induced Asthma? *How is it controlled?*_____ __yes __no

Do you have Hypertension/Cardiac conditions? *List:*_____ __yes __no

Do you have a Neurological condition? *List:* _____ __yes __no

3. <u>Heat Illness/ Nutrition:</u>

Have you suffered any heat related illness? *List:*_____ __yes __no

Are you taking any vitamins/supplements? *List*_____ __yes __no

Are you a Vegetarian? *If yes, what type?*_____ __yes __no

Have you (circle) gain/loss Weight? *If yes, how many pounds?*_____ __yes __no

Do actively participate in a Diet? *If yes, which diet?* _____ __yes __no

FEMALE student-athletes: Do you have a regular menstrual period? __yes __no

4. <u>Medications/Assistive Devices</u>:

Do you wear (circle) Glasses/Contacts? Do you wear them during activity? __yes __no

Do you wear or have (circle) False Teeth/Bridges/Veneers? __yes __no

Do you wear any Hearing Devices? *List*:_____ __yes __no

Do you wear any Protective Bracing? *(Please list all)* __yes __no

Body part/side _____ *Body part/side* _____

Body part/side _____ *Body part/side* _____

Are you currently taking any Medications? __yes __no

If yes, list medications: _____ _____

_____ _____

The preceding information is complete and correct to the best of my knowledge.

Signed: _____ **Date:** ____/____/____

Sports Medicine Staff only:
Initial: _____

Date: _____