STONY BROOK

STUDENT ATHLETE HEALTH HISTORY (2010-11)

NAME_____ TODAY'S DATE_____

(please print and use pen)

BIRTHDATE_____/_____/_____ SPORT_____ **FR/TR** (yr)____

Personal General Medical History: Have you ever had any of the following conditions?

	Yes	No		Yes	No
Anemia/Abnormal bruising/ Bleeding disorder			**Malaria**		
Acne (with medication use)			**Marfan's syndrome**		
Arthritis			**Meningitis**		
Cancer/Tumor			**Missing internal organs (spleen, kidney, etc)**		
Chicken pox			**MRSA or Staphylococcus infection**		
Constipation/Diarrhea/Hemorrhoids			**Mumps/Measles/Rubella**		
Cysts			**Pneumonia/Frequent Respiratory Infections**		
Diabetes			**Rheumatic Fever**		
Eczema/Psoriasis/any other skin condition			**Seizures Disorders**		
Gallbladder Disease/Injury			**Sickle cell disease/trait**		
Hayfever/Sinus Infections/Allergies			**Small pox**		
Hepatitis/Liver Disease			**Spleen Disease/Injury**		
Hypoglycemia			**Thyroid disease/Goiter**		
Infectious mononucleosis			**Tuberculosis/Coughing up blood**		
Irritable bowel syndrome			**Ulcers/Stomach problems**		
Kidney stones/Disease/Injury			**Urinary Problems (blood/infections)**		

Have any of your blood relatives ever had any of the following?

	Relative	Yes	No		Relative	Yes	No
Sudden death (before age 55)				**Thyroid disease/goiter**			
Arthritis/gout				**Heart attack/disease**			
Tuberculosis				**Stroke**			
Diabetes				**Epilepsy/Convulsions**			
Asthma				**Cancer**			
Blood Disease Hemophilia/sickle cell/ leukemia				**Hyperlipidemia**			
Stomach disease				**Alcohol/drug dependency**			
Kidney disease				**Marfan's syndrome**			

ALLERGIES (list all that apply)
Medications:
Insect Bites:
Environmental:
Foods:
Others (ie.Latex):
Reactions (list):

Have you ever injured or consulted with a physician about any of the following:

I. HEAD/NECK	**Yes**	**No**	**Date**
Unconscious/"knocked out"/"bell rung"			
Diagnosed concussion or head injury			
a. If yes, how many times:_____ b. Any Loss of Consciousness or amnesia? _____ c. How long to make complete recovery?_____ d. When was your last concussion?_____			
Hospitalization/surgery			
Recurrent or Severe headaches or migraines			
Fractured Skull			
Fractured your nose or jaw			
"Stinger", "Burner", numbness/tingling in your arms, hands			
Disk injury			
Dislocation/Fractures			
Sprain/strain			

II. TORSO/SPINE	**Yes**	**No**	**Date**
Fracture			
a. Clavicle (collar bone)			
b. Sternum (breast bone)			
c. Rib(s)			
Dislocation/Fractures			
Sprain/strain			
Scoliosis			
Disk injury			
a. Numbness/tingling into your buttocks, legs, feet			
b. Pain/burning into your buttocks, legs, feet			
Experienced pain while weight lifting			
Suffered from a Hernia			
a. Surgery			
Have all functioning organs (kidneys, liver, pancreas, gall bladder, intestines) please circle and explain			

III. UPPER EXTREMITY (Indicate Right or Left)			
Shoulder:	**Yes**	**No**	**Date**
a. Dislocation/subluxation			
b. AC separation/sprain/strain/bursitis			
c. Grinding or popping			
d. Surgery			

Elbow:	Yes	No	Date
a. Fractured/dislocated			
b. Sprain/strain/bursitis			
c. Surgery			
Fractured forearm			
Wrist, hand, fingers, thumb:	Yes	No	Date
a. Fractured/dislocated			
b. Sprain/strain/bursitis			
c. Surgery			
Experienced any pain throwing and/or weight lifting?			

IV. LOWER EXTREMITY (Indicate Right or Left)			
Hip & Pelvic:	Yes	No	Date
a. Fracture/stress fractures			
b. Dislocate/subluxation			
c. Strain (hamstring/quad/groin)			
d. Sprain/bursitis			
e. Hip pointer			
f. Grinding or popping pains			
g. Surgery			
Knee:	Yes	No	Date
a. Sprain/strain/bursitis/tendinitis			
b. Torn Ligaments			
c. Meniscus/cartilage			
d. Patella (kneecap) dislocation/subluxation/fracture			
e. Chondromalcia/PFC			
f. Osgood Schlatter's			
g. Any on-going problems: swelling, grinding, locking, giving way			
h. Surgery			
Lower Leg:	Yes	No	Date
a. Shin splints			
b. Stress fracture			
c. Fracture			
d. Achilles injury			
e. Compartment syndromes			

Comments:

Ankle:	Yes	No	Date
a. Sprain/strain/bursitis/tendinitis			
b. Torn Ligaments			
c. Dislocation/fracture			
d. Surgery			
e. Any on-going problems: pain, swelling, stiffness, instability			

Foot/toes:	Yes	No	Date
a. Sprain			
b. Turf toe			
c. Dislocation			
d. Fracture/stress fracture			
e. Pes planus/flat feet			
f. Plantar fasciitis			
g. Surgery			
Do you wear any type of orthotic?			

V. CARDIAC AND RESPIRATORY	Yes	No	Date
Chest pain and/or pressure			
Irregular heart beat/arrhythmia			
High blood pressure			
Dizzy, lightheaded or passed out during or after exercise			
Fatigue easily			
Heart murmur			
Asthma/exercised induced			
Shortness of breath			
Ever been to Emergency Department for difficulty breathing/intubated?			

VI. HEAT AND COLD RELATED ILLNESSES	Yes	No	Date
Passed out or fainted due to heat			
Dehydration			
Hospitalized for heat illness			
Muscle cramps due to fluid loss (from excessive heat)			
Adverse reaction to ice treatments			
Hypothermia			

Comments:

VII. EARS, EYES, DENTAL	Yes	No	Date
Loss of hearing in either ear? Or use any hearing aids?			
Loss of vision in either eye?			
Wear glasses or contacts? (please circle)			
If yes, do you wear them for athletic participation?			
Traumatic eye injury			
Fractured jaw			
Fractured tooth/Tooth knocked out			
Dental appliance: bridge, crown, caps, plates, braces (please circle)			

VIII. NUTRITIONAL	Yes	No	Date
Supplements, vitamins or nutritional aids?			
Recent weight loss or gain?			
Any specific diet regimen?			
Diagnosed with an eating disorder?			
Steroid Use?			

IX. FEMALES ONLY	Yes	No	Date
Do you have regular intervals between periods?			
If not, what is the typical duration?			
Have you ever stopped menstruating?			
Heavy bleeding during your periods?			
Severe cramps/pain during your periods?			
Average duration of your periods? _____			
Take any medications during your periods?			
Do you have both of your ovaries?			

X. MALES ONLY	Yes	No	Date
History of testicular torsion?			
Painful urination?			
Are both of your testicles present?			

XI. MENTAL	Yes	No	Date
Ever received treatment for an anxiety disorder/depression			
Experience frequent anxiety/depression?			
Ever received treatment for a personality/emotional disorder?			
Ever received treatment for substance abuse?			
Experience trouble going to sleep or staying asleep?			

XII. GENERAL INFORMATION

1. Will you require surgery for any injury/illness **PRIOR** to athletic participation at Stony Brook University? ☐ ***Yes*** ☐ ***No***
   If yes, explain: _____

2. Have you ever been told by a physician that you should **NOT** participate in athletics?
   ☐ ***Yes*** ☐ ***No***
   If yes, explain: _____

3. May the Stony Brook University Medical Staff contact this physician?

   Physician's Name_____ Phone Number (____)_____

   Address_____ City/State/Zip_____

4. List all prescription medication currently being taken:

   1._____ 3._____

   2._____ 4._____

5. Do you currently wear any supportive/protective device (brace, sleeve, support) or require taping for athletic participation?
   If so, please elaborate:_____

6. Has there been a significant injury/illness/surgery requiring physician's care over the past three years that will require medical report(s) and physician clearance for athletic activity?
   ☐ ***Yes*** ☐ ***No***
   If yes, explain: _____

By my signature, I agree that all of the preceding information is answered accurately and to the best of my knowledge. I understand that if I have fraudulently misrepresented any information regarding my medical history, institutional financial aid based on athletic ability may be reduced or canceled.

_____ _____

Student-Athlete Signature Date

Sports Medicine Staff only:
Initial: _____

Date: _____