

SUNY Maritime College Athletic Training
Medical History

Student Athlete Information (please print and complete fully)

Name: _____ Sport(s): _____

Last First Middle

Date of Birth: _____ Year: FR SO JR SR 5th Social Security #: _____

Home Address: _____

City State Zip

Home Phone# : _____

College Address: _____ Throggs Neck, NY 10465

College Phone #: _____ Cell Phone #: _____

Medical History (this information is confidential and must be complete prior to the doctors examination)

- | | | | |
|-----|--|-----|----|
| 1. | a) Have you ever been hospitalized? What for? | Yes | No |
| | b) Have you ever had surgery? On what? | Yes | No |
| 2. | Do you take medications regularly? (List medications on back) | Yes | No |
| 3. | Do you have any allergies? (List on back page) | Yes | No |
| 4. | a) Have you ever passed out during or after exercise? | Yes | No |
| | b) Have you ever been dizzy during or after exercise? | Yes | No |
| | c) Have you ever had chest pain during exercise? | Yes | No |
| | d) Have you ever had high blood pressure? | Yes | No |
| | e) Does anyone in your family have high blood pressure? | Yes | No |
| | f) Has anyone in your family died of heart problems or sudden death before age 50? | Yes | No |
| | g) Have you ever been told you have a heart murmur or heart disease? | Yes | No |
| | h) Have you ever had racing of your heart or skipped beats? | Yes | No |
| 5. | Do you have any skin problems (itching, rashes, acne)? (Explain on back page) | Yes | No |
| 6. | a) Have you ever had a head injury? | Yes | No |
| | b) Have you ever been knocked- out or unconscious? | Yes | No |
| | c) Have you ever had a concussion? | Yes | No |
| | d) If yes, how many? _____ | Yes | No |
| | e) If yes, when was your last concussion? _____ | Yes | No |
| | f) Have you ever had a seizure? | Yes | No |
| | g) Have you ever had a stinger, burner, or pinched nerve? | Yes | No |
| 7. | a) Have you had heat or muscle cramps? | Yes | No |
| | b) Have you ever had heat exhaustion? | Yes | No |
| 8. | Do you have asthma or take medication for asthma? | Yes | No |
| 9. | Do you require any special equipment or padding? (Explain on back page) | Yes | No |
| 10. | Do you wear glasses, contacts, or protective eyewear? Which one _____ | Yes | No |
| 11. | Have you ever been told you are missing one of a paired organ? _____ | Yes | No |
| 12. | Have you ever been told not to participate in physical activity by a doctor? (Explain) | Yes | No |
| 13. | a) Have you lost more than 10 pounds over the last 2 months? | Yes | No |
| | b) Have you lost more than 20 pounds over the last year? | Yes | No |
| 14. | Have you had any other medical problems (i.e., infections, mononucleosis, diabetes)? | Yes | No |

15. Have you ever sprained/ strained, dislocated, fractured/ broken, had repeated swelling or other injuries of any joints/bones listed? (please circle all that apply and explain in the lines provided with the approximate date of injury)

- circle:
- | | | | | |
|-------------|--------------|----------|-----------|-----------|
| 1. Head | 4. Shin/Calf | 7. Neck | 10. Ankle | 13. Chest |
| 2. Forearm | 5. Thigh | 8. Wrist | 11. Knee | 14. Hand |
| 3. Shoulder | 6. Back | 9. Elbow | 12. Hip | 15. Foot |

Explain all yes answers to question 15: (Include date and procedure/injury)

- | | | |
|---|-----|----|
| 16. Are your immunizations up to date? | Yes | No |
| 17. Have you ever been treated for an eating disorder? | Yes | No |
| 18. Females Only: | | |
| a) When was your last menstrual cycle? _____ | | |
| b) Do you have irregular menstrual cycles? | Yes | No |
| b) Have you ever missed a menstrual cycle? | Yes | No |
| c) What was the longest time between your cycles last year? _____ | | |

Please explain "yes" answers for questions 1-14 below:

To the best of my knowledge the above information is correct. I understand that falsifying information could be detrimental to my health.

Student's Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____