ATHLETE MEDICAL HISTORY QUESTIONNAIRE 2018-2019

(FOR ATHLETIC TRAINER)

INSTRUCTIONS:

1. To be completed each season that the student-athlete participates in athletics at Mt. Abram High School.
2. Please follow directions and complete ALL sections.
3. Student-athlete and Parent / Guardian signature is required allowing care by Certified Athletic Trainer.

*** ALL Information remains confidential and is only used for providing care to the student-athlete.

Today's Date: ______________________________ Student's Date of Birth: ________________________________

Last Name: ______________________________________ First Name: ___________________________________

Grade: FR / SO / J R / SR   Gender: Male / Female   Season: Fall / Winter / Spring

Sport: ____

Home Address:

____

Secondary Address: (if you reside with someone else part-time):

____

Home Phone #: ______________________________ Secondary Address Phone #: ____________________________

Parent / Guardian (MOM) Name: ____

Work #: ____ Cell #: ____

Parent / Guardian (DAD) Name: ____

Work #: ____ Cell #: ____

With whom do you make your primary residence?: (Mom, Dad, Other) ___________________________________

Emergency Contact: (in the event of emergency and parents / guardians cannot be reached)

Name: ____ Relationship to Athlete: ____________________

Home Phone #: _______________________ Work #: _____________________ Cell #:

____

Student's Primary Care Physician: _______________________________________ Phone #: __________________

Health Insurance Info: ____ HMO / PPO

Do you need a referral from your insurance company for medical services (except emergencies)? ______________

Are you allergic to any medications?

____

Do you have any other allergies? ____

Do you suffer from Asthma? __________________________ Do you carry an inhaler? _________________________

Are you diabetic? ___________________________________ Are you Epileptic? _____________________________

Are you currently taking any medication? _______________________, if so what? ___________________________

____

Do you wear contact lenses? ____

Please CIRCLE any of the following that you have had, or are currently receiving treatment for:

anemia	appendicitis	eating disorder	bladder injury / illness
diabetes	epilepsy	headaches	heart disease
hernia	spleen injury	high / low blood pressure	kidney disease / injury
liver disease / injury	Lupus	measles	menstrual disorder
pneumonia	rheumatoid arthritis	stomach trouble	Lyme disease
nose bleeds	vomiting during sports	mono	

Explain any circled answers:

____

____

____

Have you ever suffered a concussion?

____ If yes, Approximate Date(s):

____

Treatments received for concussions: ____

Have you ever suffered a neck or back injury?: ____

If yes, explain and give approximates dates:

____

Have you ever suffered a joint injury (fracture, dislocation, sprain, etc.)?

____

If yes, explain and give approximate dates:

____

Have you "passed out" during activity?: ____

Have you had "chest pain" during activity?:

____

Have you had abnormal heart beats during activity?: ____

Is there anything else the Athletic Trainer should know about your overall health?:

____

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To the best of my knowledge, all of the information in this Questionnaire is accurate!

Student-Athlete Signature: ____ Date:
____

Parent / Guardian Signature: ____ Date: ____________________