Wichita State University-ICAA
Medical History Questionnaire

Name ____________________________________  Date _________________________

Instructions: Please circle your answers. When a reply is yes, please give data of injury or treatment on the line below the yes. Indicate as near as possible the location of the injury, i.e. right/left, etc. The information that you provide is confidential and it is imperative that you fill out the questionnaire to the best of your knowledge.

Yes  No 1. Have you ever experienced an epileptic seizure or been informed that you might have epilepsy?

Yes  No 2. Have you ever been treated for hepatitis? What type, A, B, C?

Yes  No 3. Have you ever been treated for mononucleosis, a virus, pneumonia, or any other infectious diseases in the last month? If so, please list which one ________________________________________________________.

Yes  No 4. Have you ever been diagnosed with diabetes?

Yes  No 5. Have you ever been diagnosed with meningitis?

Yes  No 6. Have you ever been diagnosed with asthma?

Yes  No 7. Have you ever been diagnosed with high blood pressure?

Yes  No 8. Have you ever had tuberculosis?

Yes  No 9. Have you ever been tested for tuberculosis? If yes, when? ________________

Yes  No 10. Have you ever been treated for or informed by a physician that you have rheumatic fever?

Yes  No 11. Is there a family history of early (before age 50) heart disease, heart attack in a relative that has led to disability or sudden death?

Yes  No 12. Have you been told that you have lost or were born with a single kidney, eye, testicle, ovary or other organ? If yes, please list__________________________________________.

Yes  No 13. Have you ever been told that you or a family member have a heart murmur, or any other heart condition such as Marfan’s Syndrome, Long QT Syndrome or ion channelopathies, Hypertrophic Cardiomyopathy, Dilated Cardiomyopathy, or arrhythmias? If yes, please list family member and condition__________________________________________________________.

Yes  No 14. Have you been tested or told you have sickle cell disease or trait? If so, please list date tested and results of the test. ____________________________
Yes  No  15. Have you ever had chest pain or dizziness during or after activity?

Yes  No  16. Have you ever had racing of your heart or a skipped heart beat during or after activity?

Yes  No  17. Have you ever had excess fatigue or shortness of breath compared with your teammates during equal activity?

Yes  No  18. Have you ever passed out during or after activity?

Yes  No  19. Have you ever been “knocked out” or experienced a concussion during the past three years?

If yes, please indicate number of concussions, dates or season, and year.

___________________________________________________________

Yes  No  20. Have you ever been told that you have a hernia?

If yes has the hernia been surgically repaired and when? ______________

Yes  No  21. Is there a family history of any other diseases? Please list.

____________________________________________________________

____________________________________________________________

Yes  No  22. Do you wear glasses or contact lenses? If so, please state: ______________

___________________________________________________________

Yes  No  23. Do you wear any dental appliance? If yes, please state:__________________

___________________________________________________________

Yes  No  24. Do you have any allergies to foods, drugs, or ANY other substances?

If yes, please list:______________________________________________

___________________________________________________________

Yes  No  25. Are you or have you ever taken any supplements, herbs or vitamins?

If yes, please list:______________________________________________

___________________________________________________________

Yes  No  26. Have you ever had Anorexia or Bulimia? If yes, please state:

Yes  No  27. Are you currently taking any prescription medications on a regular basis? If yes please indicate the name of the drug and the condition for which it is prescribed.

___________________________________________________________

Yes  No  28. Have you ever suffered an injury due to heat? If yes, when?______________

___________________________________________________________

Yes  No  29. Have you ever had a fracture or broken bone? If yes, please indicate site of fracture, side of the body, injury date, and if it has resolved.

___________________________________________________________
30. Have you ever had a stress fracture? If yes, please indicate site of fracture, side of the body, injury date, and if it has resolved.

__________________________________________________________

31. Have you ever had a dislocated joint? If yes, please indicate site of dislocation, side of the body, injury date, and if the injury has resolved.

__________________________________________________________

32. Have you ever had a stinger, burner or pinched nerve? If yes, please indicate site of injury, side of body, injury date, and if the injury has resolved.

__________________________________________________________

33. Do you have a pin, screw or plate somewhere in your body as a result of bone or joint surgery? If yes, please indicate the site, side of the body, date of surgery and if the injury has resolved.

__________________________________________________________

34. Have you had any operations or surgeries? If yes, please indicate site, side of the body, the date of surgery or operation, and if the injury has resolved.

__________________________________________________________

35. Have you ever injured any of the following? If yes please indicate injury, side of the body, date of injury, and if it has resolved.

Shoulder _________________________ Hip ______________________________
Elbow ___________________________ Knee _____________________________
Wrist ____________________________ Ankle _____________________________
Hand ____________________________ Foot _____________________________
Neck ____________________________ Back _____________________________

36. Have you ever been advised by a medical doctor not to participate in sports? If yes, please indicate for what reason.

__________________________________________________________

37. Have you ever been disqualified or told not to compete by a physician due to an injury or illness at another university? If yes, please indicate for what reason.

__________________________________________________________

38. Have you had any illnesses or injuries since your last years physical? If yes, please list:

__________________________________________________________

39. Do you have any current concerns you would like to discuss with a physician?
40. What was your highest weight during your athletic career? Please tell us when and for how long. ____________________________________________

41. What was your lowest weight during your athletic career? Please tell us when and for how long. ____________________________________________

Yes No 42. Are you currently trying to control your weight? If so, how: ____________________________________________________________

WOMEN:
Yes No 43. Do you have regular periods?

44. Age of first period: ____________________________________________

45. Date of last period: ____________________________________________

46. Number of periods per year: ____________________________________

47. What is the longest you have ever gone without having a period?

______________________________________________________________

Yes No 48. Do your periods become less frequent during your training or sports season?

Yes No 49. Do you take birth control pills? If so, how regular were your periods before the birth control pills? _______________________________________

Immunizations: New student-athletes at Wichita State University, please send a copy of your immunization record.

Please list any other medical information that is not listed above. Please be specific.

________________________________________________________________________

________________________________________________________________________

I certify that the above information is true to the best of my knowledge.

Student-Athlete’s Signature _____________________________ Date: ____________________

5/3/2010