UNIVERSITY OF NOTRE DAME
SPORTS MEDICINE
MEDICAL HISTORY QUESTIONNAIRE 2011-2012

PLEASE TYPE OR PRINT ALL INFORMATION CLEARLY
When completed, click on Submit by Email. If the submit Email button does not work you're your email program, please send by Fax to: 574-631-5011 or bring to the front desk of the University Health Services, St. Liam Hall.

Name:_____ Sport:_____
Last First M.I.

Home Address:_____

City:_____ State:_____ Zip:_____

Campus Address: _____

Home Telephone:_____ Cell Phone:_____

Date of Birth:_____ Age:_____

Entry to Notre Dame: Year _____Semester: _____ Notre Dame ID#_____

Father's Name:_____ Telephone:_____

Mother's Name_____ Telephone:_____

GENERAL HEALTH
Please check Yes or No for each question

1. Do you have an on-going medical condition ? **Yes___ No___**
If yes, please explain_____

3. Have you ever been told by a doctor that you had a "heart condition"? **Yes___No___**
If yes, please explain_____

4. Check any of these that apply to you:
High Blood Pressure___ Heart Murmur___ Heart Infection___
High Cholesterol___ ADHD___

5. Does anyone in your immediate family have a "heart condition"? **Yes___No___**
If so, who?_____

6. Has any family member or relative died of heart problems or of sudden death before age 50? **Yes___No___**

7. Have you ever been told by a doctor that you have asthma? **Yes___No___**

8. Do you cough, wheeze, or have difficulty breathing during/after exercise? **Yes___No___**

9. Has a doctor told you that you or someone in your family had sickle cell trait or sickle cell disease? **Yes___No___**

Have you ever had ANY problems, or an injury to your:

ANKLES? **Yes___No___** Right/Left/ or Both_____

If yes, approximate dates:_____

What was the nature of the problem(s)?_____

Were you examined by a physician? Yes___No___ If yes, please state the following:

Physician_____City_____State_____

Was surgery involved? Yes___No___ (If the physician who performed the surgery is not the one listed above, please provide us with the name of the surgeon, city, and state on the back of this page.)

KNEES? **Yes___No___** Right/Left/ or Both_____

If yes, approximate dates:_____

What was the nature of the problem(s)?_____

Were you examined by a physician? Yes___No___ If yes, please state the following:

Physician_____City_____State_____

Was surgery involved? Yes___No___ (If the physician who performed the surgery is not the one listed above, please provide us with the name of the surgeon, city, and state on the back of this page.)

LOWER, UPPER, OR MID BACK? **Yes___No___**

If yes, approximate dates:_____

What was the nature of the problem(s)?_____

Where you examined by a physician? Yes___No___ If yes, please state the following:

Physician_____City_____State_____

Was surgery involved? Yes___No___(If the physician who performed the surgery is not the one listed above, please provide us with the name of the surgeon, city, and state on the back of this page.)

SHOULDERS? **Yes___No___** Right/Left/ or Both_____

If yes, approximate dates:_____

What was the nature of the problem(s)?_____

Where you examined by a physician? Yes___No___ If yes, please state the following:

Physician_____City_____State_____

Was surgery involved? Yes___No___(If the physician who performed the surgery is not the one listed above, please provide us with the name of the surgeon, city, and state on the back of this page.)

ELBOWS? **Yes___No___** Right/Left/ or Both_____

If yes, approximate dates:_____

What was the nature of the problem(s)?_____

Where you examined by a physician? Yes___No___ If yes, please state the following:

Physician_____City_____State_____

Was surgery involved? Yes___No___(If the physician who performed the surgery is not the one listed above, please provide us with the name of the surgeon, city, and state on the back of this page.)

HANDS/WRISTS? **Yes___No___** Right/Left/ or Both_____

If yes, approximate dates:_____

What was the nature of the problem(s)?_____

Where you examined by a physician? Yes___No___ If yes, please state the following:

Physician_____City_____State_____

Was surgery involved? Yes___No___(If the physician who performed the surgery is not the one listed above, please provide us with the name of the surgeon, city, and state on the back of this page.)

HIPS? **Yes___No___** Right/Left/ or Both_____

If yes, approximate dates:_____

What was the nature of the problem(s)?_____

Where you examined by a physician? Yes___No___ If yes, please state the following:

Physician_____City_____State_____

Was surgery involved? Yes___No___(If the physician who performed the surgery is not the one listed above, please provide us with the name of the surgeon, city, and state on the back of this page.)

NECK and/or BURNERS? **Yes___No___** Right/Left/ or Both_____

(a Burner is a nerve injury that causes stinging or numbness in your shoulder and arm)

If yes, approximate dates:_____

What was the nature of the problem(s)?_____

Were you examined by a physician? Yes___No___ If yes, please state the following:

Physician_____City_____State_____

Was surgery involved? Yes___No___(If the physician who performed the surgery is not the one listed above, please provide us with the name of the surgeon, city, and state on the back of this page.)

HEAD INJURIES or CONCUSSIONS? **Yes___No___**

(please include fainting or dizzy spells)

If yes, approximate dates:_____

What was the nature of the problems(s)?_____

Where you examined by a physician? Yes___No___ If yes, please state the following:

Physician_____City_____State_____

Was surgery involved? Yes___No___(If the physician who performed the surgery is not the one listed above, please provide us with the name of the surgeon, city, and state on the back of this page.)

EYES/VISION?

Do you have vision in both eyes? **Yes___No___** Right/Left/ or Both_____

Have you ever had an eye injury? **Yes___No___** Right/Left/ or Both_____

If yes, approximate dates:_____

What was the nature of the problem(s)?_____

Where you examined by a physician? Yes___No___ If yes, please state the following:

Physician_____City_____State_____

Was surgery involved? Yes___No___(If the physician who performed the surgery is not the one listed above, please provide us with the name of the surgeon, city, and state on the back of this page.)

Do you wear? **Glasses___** **Contact Lenses___**

If your optometrist is different than the physician listed above, please list the following:

Physician_____City_____State_____

ORAL/DENTAL?

Have you ever had an injury to your teeth or jaw? **Yes___No___**
If yes, approximate dates:_____
What was the nature of the problem(s)?_____
Where you examined by a dentist/oral surgeon? Yes___No___If yes, please state the following:
Physician_____City_____State_____
Was surgery involved? Yes___No___(If the physician who performed the surgery is not the one listed above, please provide us with the name of the surgeon, city, and state on the back of this page.)
Do you wear? Plate___Bridge___Braces___Retainer___

OTHER

Do you have only 1 of any "pair" (eyes, kidney, hand, etc.)? **Yes___No___**
If yes, please list:_____

Do you take any prescription medications on a regular basis? **Yes___No___**
If yes, please list:_____

Have you ever been diagnosed with ADHD or ADD? **Yes___No___**
If yes, do you currently take any meds for this? **Yes___No___**

Do you have any allergies? **Yes___No___**
If yes, what type: Drug___ Insect___ Food___ Enviromental___
Please explain:_____

Please list any other major injuries, illnesses, and surgical procedures that may have not been covered in previous sections of this questionnaire.

_____
_____
_____
_____
_____

Do we have permission to contact your physician(s) to request xrays, diagnostic test reports, surgical reports, or clinical notes for the injuries or medical conditions listed on this form?
Yes___No___

SIGNATURE

I have completed this questionnaire honestly and to the best of my ability.

Signed:_____Date:_____
Athlete

Signed:_____Date:_____
Parent – if the athlete is younger than 18