Vernon College - Athletic Training Athlete Pre-Participation Health History Form

This form is meant to function only as a screening tool and does not take the place of pre-participation exam by Vernon College team physicians. Check "yes or no" in the appropriate box. Please provide specific responses in detail to all "yes" answers (date, location, etc). This information will remain confidential at all times from parents (if over 19 yrs of age) and coaches.

Student-Athlete Name (Last, First, MI)		Social Security # - -
Date of Birth / /	Sport	Returner OR New / Transfer FR / SO / 3rd Year
Email		Cell # ( )
List all allergies (environmental, medications, food, insect related)		Date of last tetanus shot / /
List all current medications, inhalers, and/or supplements		

Family History

Has anyone in your immediate family ever had:	YES	NO	Explain in detail below (relation, age, etc)
Diabetes			
Sudden death (less than age 50)			
High Blood Pressure			
Heart Attack (less than age 50)			
Asthma			
High Cholesterol			

General Health History

*****Remember all questions are strictly CONFIDENTIAL and will not be shared with parents or coaches*****

Are you currently under a physician's care for any medical conditions?	YES	NO	Describe:
Have you had a viral infection (mononucleosis, myocarditis, etc) within the last 6 months?	YES	NO	Describe:
Have you been hospitalized for any illness or injury in the last 6 months?	YES	NO	Describe:
Have you ever had seizures, convulsions, and/or epilepsy?	YES	NO	Describe:
Do you suffer from headaches or migraines?	YES	NO	Describe frequency & location:
Do you cough, wheeze, or have trouble breathing during or after exercise/practice?	YES	NO	Describe:
Do you have asthma or exercised induced Asthma?	YES	NO	Describe:
Do you have or been advised that you have High Cholesterol?	YES	NO	
Do you have or been advised that you have Diabetes?	YES	NO	
Do you have or been advised that you have High Blood Pressure?	YES	NO	
Do you have or been advised that you have Anemia?	YES	NO	
Do you have ringing in your ears, trouble hearing or a perforated eardrum?	YES	NO	Describe:
Do you have ear infections or nosebleeds?	YES	NO	Describe:
Do you have dental implants or orthodontic work?	YES	NO	Describe:
Do you wear or wish to wear a mouthguard (custom or over-the-counter)?	YES	NO	Describe:
Do you have unequal pupils, impaired vision, and/or wear glasses/contacts?	YES	NO	Describe:

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Head / Facial Injuries and Concussions	Have you ever suffered an injury to the mouth, jaw and/or teeth?	YES	NO	Date of Injury(s):
	Please describe injury & recovery time of mouth/jaw/teeth injury:			
	Have you ever suffered a head injury or concussion (no matter how minor)?	YES	NO	Date of Injury(s):
	Please describe injury & recovery time of head injury/concussion:			
	Have you ever suffered any of the following (Circle all that apply)? Knocked Out / Loss of Consciousness / Loss of Memory	YES	NO	Describe:
	Have you ever been evaluated by a physician for a head injury or concussion?	YES	NO	Describe:
	Circle any diagnostic tests performed below. X-Ray / MRI / CT Scan / Neuropsychological / Other	Describe results:		
	Have you ever been hospitalized for a head injury/concussion?	YES	NO	Date & Location of Hospitalization:
	Have you ever been advised not to participate in athletic activities due to a head injury or concussion?	YES	NO	Describe:
Heat Illnesses	Have you ever suffered from a heat related injury (Circle all that apply)? Heat Cramps / Heat Syncope-Fainting / Heat Exhaustion / Heat Stroke	YES	NO	Date and Describe:
	Have you ever been hospitalized for a heat related problem?	YES	NO	Date & Location of Hospitalization:
	Have you ever been advised not to participate in athletic activities due to a heat related injury?	YES	NO	Describe:
Dermatological	Do you have any skin problems that we should be aware of (herpes/cold sores, itching, rashes, acne, warts, eczema, fungus, etc)	YES	NO	Describe:
	Have you been diagnose with a MRSA or Staphylococcus infection?	YES	NO	Date and Describe:
	Have you ever been under the care of a dermatologist?	YES	NO	Describe:
	Have you ever been advised not to participate in athletic activities due to a skin condition?	YES	NO	Date & Location of Hospitalization:
Mental Health and Nutrition	Have you ever had or currently have the following? (please circle all that apply) Anxiety / Depressive Thoughts / Insomnia / Other	Please describe & explain frequency/history of treatment if any:		
	Do you feel stressed out? If yes, do you feel as though you get the necessary support to deal with your stress?	YES	NO	Describe:
	Have you ever been under the care of a psychiatrist and /or psychologist?	YES	NO	Date and Describe
	Has your weight changed (loss or gain) more than 10lbs in the past year?	YES	NO	
	Do you have a history of anorexia, bulimia, and/or any other eating disorder?	YES	NO	

ADHD ADD	Are you currently being treated for Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD)?	YES	NO	Please list current medications below:
Sickle Cell Trait	Have you ever been tested for or advised that you carry the trait for Sickle Cell Anemia?	YES	NO	Please list the date and results below and provide a copy of your results.
	Does any member of you family carry the Sickle Cell Trait or currently have Sickle Cell Anemia?	YES	NO	If yes, please state relation.

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Females Only	Do you have an irregular menstrual cycle?			
	What is your longest time between periods in the last year?			
	What was the approximate age of your first period?			
Abdomen, Chest, Ribs, and Thorax	Have you ever suffered an injury to your abdomen/chest/ribs/thorax?	YES	NO	Date of Injury:
	Please describe injury & recovery time:			
	Circle any diagnostic tests performed below. X-Ray / MRI / CT Scan / Bone Scan / Other	Describe results:		
	Were you ever been hospitalized?	YES	NO	Date & Location of Hospitalization:
	Have you ever had surgery of any kind on your abdomen/chest/ribs/thorax?	YES	NO	Date, Surgeon, & Hospital:
	Please describe the surgical procedure, recovery time, etc.			
	Have you ever undergone rehabilitation for your abdomen, ribs, thorax or chest with an athletic trainer or physical therapist?	YES	NO	Describe:
	Have you ever been advised not to participate in athletic activities due to an abdominal/chest/ribs/thorax injury?	YES	NO	Describe:
	Have you ever had or been told you have an abdominal or sports hernia?	YES	NO	Describe:
	Have you ever had a stomach and/or duodenal ulcer?	YES	NO	Describe:
	Do you routinely suffer from severe or recurrent abdominal pain?	YES	NO	Describe:
	Do you routinely suffer from chronic or recurrent diarrhea?	YES	NO	Describe:
	Do you have only one of two paired functioning organs (kidney, testicles, ovary, etc)?	YES	NO	Describe:
	Do you suffer from any type of urological or genital disorder?	YES	NO	Describe:
Cervical Spine and Neck	Have you ever suffered an injury to your cervical spine and/or neck?	YES	NO	Date of Injury:
	Please describe injury & recovery time:			
	Circle any diagnostic tests performed below. X-Ray / MRI / CT Scan / Bone Scan / Other	Describe results:		
	Were you ever been hospitalized?	YES	NO	Date & Location of Hospitalization:
	Have you ever had "Burners, Stingers, or Brachial Plexus" Injuries or any numbness &/or tingling in your arms/fingers?	YES	NO	Date of Injury:
	Please describe injury (right/left/both) & recovery time:			
	Have you ever had surgery of any kind on your cervical spine/ neck?	YES	NO	Date, Surgeon, & Hospital:
	Please describe the surgical procedure, recovery time, etc.			
	Have you ever been advised not to participate in athletic activities due to a cervical spine/ neck injury?	YES	NO	Describe:
	Do you presently or have you ever worn or been advised to wear a "neck roll", "cowboy collar" or "helmet restrictor plate"?	YES	NO	Describe:

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Spine, Low Back, and Sacroiliac Joint	Have you ever suffered an injury to your spine, low back, or SI joint?	YES	NO	Date of Injury:
	Please describe injury & recovery time:			
	Circle any diagnostic tests performed below. X-Ray / MRI / CT Scan / Bone Scan / Other	Describe results:		
	Were you ever been hospitalized?	YES	NO	Date & Location of Hospitalization:
	Please describe injury & recovery time:			
	Have you ever undergone rehabilitation for your spine, low back or SI joint with an athletic trainer or physical therapist?	YES	NO	Describe:
	Have you ever had surgery on your spine, low back or SI Joint?	YES	NO	Date, Surgeon & Hospital:
	Please describe the surgical procedure, recovery time, etc.			
	Do you currently or have you ever had numbness/tingling down one or both legs?	YES	NO	Describe:
	Have you ever been advised not to participate in athletic activities due to a spine, low back or SI joint injury?	YES	NO	Describe:
Shoulder and Upper Arm	Have you ever suffered an injury to your shoulder or upper arm?	YES	NO	Date of Injury:
	Please describe injury & recovery time:			
	Circle any diagnostic tests performed below. X-Ray / MRI / CT Scan / Bone Scan / Other	Describe results:		
	Have you every suffered a dislocated or subluxed shoulder?	YES	NO	Date of Injury:
	Were you ever been hospitalized?	YES	NO	Date & Location of Hospitalization:
	Please describe injury & recovery time:			
	Have you ever undergone rehabilitation for your shoulder or upper arm with an athletic trainer or physical therapist?	YES	NO	Describe:
	Have you ever had surgery of any kind on your shoulder/upper arm?	YES	NO	Date, Surgeon & Hospital:
	Please describe the surgical procedure, recovery time, etc.			
	Have you ever been advised not to participate in athletic activities due to a shoulder or upper arm injury?	YES	NO	Describe:
	Have you ever had to "take time off" from throwing due to shoulder pain or rehabilitation?	YES	NO	Describe:
Elbow and Forearm	Have you ever suffered an injury to your elbow or forearm?	YES	NO	Date of Injury:
	Please describe injury & recovery time:			
	Circle any diagnostic tests performed below. X-Ray / MRI / CT Scan / Bone Scan / Other	Describe results:		
	Were you ever been hospitalized?	YES	NO	Date & Location of Hospitalization:
	Please describe injury & recovery time:			
	Have you ever undergone rehabilitation for your elbow or forearm with an athletic trainer or physical therapist?	YES	NO	Describe:
	Have you ever had surgery of any kind on your elbow or forearm?	YES	NO	Date, Surgeon & Hospital:
	Please describe the surgical procedure, recovery time, etc.			
	Have you ever been advised to take time off or not participate in athletic activities due to an elbow or forearm injury?	YES	NO	Describe:

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Wrist, Hand, and Fingers	Have you ever suffered an injury to your wrist, hand, or fingers?	YES	NO	Date of Injury:
	Please describe injury & recovery time:			
	Circle any diagnostic tests performed below. X-Ray / MRI / CT Scan / Bone Scan / Other	Describe results:		
	Were you ever been hospitalized?	YES	NO	Date & Location of Hospitalization:
	Please describe injury & recovery time:			
	Have you ever undergone rehabilitation for your wrist/hand/fingers with an athletic trainer or physical therapist?	YES	NO	Describe:
	Have you ever had surgery of any kind on your wrist/hand/fingers?	YES	NO	Date, Surgeon & Hospital:
	Please describe the surgical procedure, recovery time, etc.			
	Have you ever been advised not to participate in athletic activities due to a wrist/hand/fingers injury?	YES	NO	Describe:
Hip, Groin, Hamstring & Quadriceps	Have you ever suffered an injury to your hip/groin (including hernias or sports hernias) or hamstring/quadriceps?	YES	NO	Date of Injury:
	Please describe injury & recovery time:			
	Circle any diagnostic tests performed below. X-Ray / MRI / CT Scan / Bone Scan / Other	Describe results:		
	Where you ever been hospitalized?	YES	NO	Date & Location of Hospitalization:
	Please describe injury & recovery time:			
	Have you ever undergone rehabilitation for your hip/ groin/ hamstring/quadriceps with an athletic trainer or physical therapist?	YES	NO	Describe:
	Have you ever had surgery?	YES	NO	Date, Surgeon & Hospital:
	Please describe the surgical procedure, recovery time, etc.			
	Have you ever been advised not to participate in athletic activities due to a hip/groin/hamstring/quadriceps injury?	YES	NO	Describe:
Knee and Patella	Have you ever suffered an injury to your knee or patella (kneecap)?	YES	NO	Date of Injury:
	Please describe injury & recovery time:			
	Circle any diagnostic tests performed below. X-Ray / MRI / CT Scan / Bone Scan / Other	Describe results:		
	Were you ever been hospitalized?	YES	NO	Date & Location of Hospitalization:
	Please describe injury & recovery time:			
	Have you ever undergone rehabilitation for your knee or patella with an athletic trainer or physical therapist?	YES	NO	Describe:
	Have you ever had surgery of any kind on your knee or patella?	YES	NO	Date, Surgeon & Hospital:
	Please describe the surgical procedure, recovery time, etc.			
	Have you ever been advised not to participate in athletic activities due to a knee or patella injury?	YES	NO	Describe:
	Have you ever or do you presently wear a knee brace?	YES	NO	Describe reason for wearing:

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Lower Leg, Ankle, & Foot	Have you ever suffered an injury to your lower leg, ankle or foot?	YES	NO	Date of Injury:
	Please describe injury & recovery time:			
	Circle any diagnostic tests performed below. X-Ray / MRI / CT Scan / Bone Scan / Other	Describe results:		
	Were you ever been hospitalized?	YES	NO	Date & Location of Hospitalization:
	Please describe injury & recovery time:			
	Have you ever undergone rehabilitation with an athletic trainer or physical therapist?	YES	NO	Describe:
	Have you ever had surgery of any kind on your lower leg, ankle or foot?	YES	NO	Date, Surgeon & Hospital:
	Please describe the surgical procedure, recovery time, etc.			
	Have you ever been advised not to participate in athletic activities due to a lower leg, ankle or foot injury?	YES	NO	Describe:
	Have you ever had a stress fracture(s)?	YES	NO	Describe:
	Have you ever or do you presently utilize orthotics or shoe inserts?	YES	NO	Describe reason for wearing:
	Have you ever or do you presently tape or wear ankle brace(s)?	YES	NO	Describe reason for wearing:

Please describe below any additional illness(s) and/or injury(s) information which is knowledgeable to you and not mentioned above on this form.

I, the undersigned, hereby acknowledge, affirm, and represent that all statements in this form are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that my health and physical welfare may jeopardized as result and that I may suffer physical harm. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that I will be responsible for any medical charges incurred.

_____ _____

Student-Athlete Signature **Date**

_____ _____

Parent/Guardian Signature (If under 19 years of age) **Date**

_____

Parent/Guardian Print Name

_____ _____

VC ATHLETIC TRAINER SIGNATURE **DATE**