

**GRAND CANYON UNIVERSITY ATHLETIC TRAINING
2007-08 HEALTH HISTORY QUESTIONNAIRE**

This information is confidential. Please answer all questions fully and explain all "Yes" answers in the space provided. This form must be completed and returned before the student-athlete will be permitted to practice or compete. Further medical evaluations may be required for specific problems.

Name _____ Date _____

Sport _____ Social Security # _____

GENERAL INFORMATION

1. Please list any prescription or non-prescription medications, supplements or vitamins you are taking on a regular basis (including birth control pills).

2. Please list ALL allergies to medications, environmental substances, adhesives, or any other allergies you may suffer from.

Yes	No	Question:	If yes, please explain:
		Have you ever had surgery or have been advised to have surgery at any time in your life?	
		Have you ever had any illness that lasted longer than one week or caused you to miss a practice or a game?	
		Have you ever been hospitalized overnight or longer?	
		Are you currently ill or have you been ill within the past four weeks?	
		Have you had any problems with environmental heat or cold illness?	
		Have you ever fainted, felt like fainting or became dizzy during exercise?	
		Do you have any history of chest pain, or irregular heart rhythm at rest, during or after exercise?	
		Do you have any loss or impairment of internal organs?	
		Do you have a bleeding disorder (anemia, hemophilia)?	
		Do you think you have problems with your weight or have an eating disorder?	
		Do you have any history of frequent (more than 3x a week) diarrhea or constipation?	
		Do you know of any health reason why you should not participate in Grand Canyon Univ. Intercollegiate Athletics at this time?	
		Have you ever been instructed by a physician to NOT participate in any sport activity?	

Please indicate if you have a history of any of the following:

Yes	No	Medical Condition:	Yes	No	Medical Condition:	Yes	No	Medical Condition:
		Seizures			Tuberculosis			Asthma
		Hepatitis			Mononucleosis			Rheumatic fever
		Abdominal infections			Abdominal trauma			High blood pressure
		Diabetes			Collapsed lung			Arthritis
		Bronchitis			Scarlet fever			Heart murmur
		Pneumonia			Thyroid disease			Other: _____

HEAD AND NECK

Yes	No	Question	If yes, please explain:
		Have you had any head injury, concussion (loss of consciousness, fainting, knockout, blurred vision, “dinged”) during the past three (3) years?	
		Do you have abdominal hearing in either ear or abnormal vision in either eye (including color blindness)?	
		Do you wear contacts or glasses?	
		Do you have frequent headaches or headaches after exercise (not related to injury)?	
		Do you have a history of a fracture, injury or pain in the face, jaw, teeth, skull or nose?	
		Do you have any teeth or gum discomfort, broken or missing teeth, or do you wear a removable dental appliance?	
		Have you been advised to have any dental (teeth or gum) surgery, procedure (fillings, caps, crowns, etc) that has not been done?	

ORTHOPEDIC

Yes	No	Question	If yes, please explain:
		Have you ever had a fracture, dislocation, ligamentous, or cartilage injury?	
		Have you been advised to have any orthopedic surgery (bones, joints, ligaments, cartilage or disc) at any time in your life?	

Please indicate if you have had any of the following:

Yes	No	Medical Condition:	Yes	No	Medical Condition:
		Stress fracture			Shoulder impingement
		Chondromalacia			Osteomyelitis
		Osgood-Schlatters Disease			Patellar tendinitis
		“Little league elbow”			Achilles tendinitis
		Shin splints (MTSS)			Burner or stinger
		Rotator cuff tendinitis			Other: _____

FAMILY HISTORY

Yes	No	Question	If yes, please explain:
		Has any blood relative(s) died before the age of 50 from natural causes (heart disease, cancer, etc) or from unexplained causes?	

Please indicate if any **blood relative(s)** (Mother, Father, Sisters, Brothers, Grandparents...) have had any of the following:

Yes	No	Medical Condition:	Yes	No	Medical Condition:	Yes	No	Medical Condition:
		High blood pressure			Asthma			Cancer
		Stroke			Chronic bronchitis			Diabetes
		Heart attack			By-pass surgery			Sickle-cell disease
		Migraine/chronic headaches			Kidney disease			Skin disorders
		Drug/alcohol dependency			Nerve disorders			Intestine disorders
		Other:			Other:			Other:

ADDITIONAL FEMALE HISTORY

Yes	No	Question	If yes, please explain:
		Have you failed to menstruate for more than three (3) consecutive months?	
		Do you have irregular cycles: less than 21 days or more than 35 days?	
		Do you have abnormal menstrual flow: less than 2 days or more than 7 days?	
		Would you like to speak with a health care professional about women's health?	

Please utilize this space for additional responses to "yes" answers.

ALL STUDENT-ATHLETES

The undersigned, herewith:

- A. Understands that he/she must refrain from practice or competition during medical treatment until they are discharged from treatment or given a written permit by the attending physician to resume participation.
- B. Certifies that the answers to these questions are true and correct.
- C. Understands that he/she having passed the physical examination does not necessarily mean that he/she is physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify him/her.
- D. Fully realizes that Grand Canyon University cannot be held responsible for any previous conditions that he/she might have.
- E. Understands permission to participate will not be granted until these forms are completed and signed by the certified athletic trainer.

Student-athlete's Signature _____ Date _____

If minor:

Parent / Guardian Signature _____ Date _____

Certified Athletic Trainer's Signature _____ Date _____