

RETURNING - Student Athlete Medical History Questionnaire

SUNY College at Brockport Department of Athletics and Health & Counseling

Name:	date of birth:	sex:	M	F
Banner or ID #	sport (s):			
Emergency contact name and #:				
Local address/dorm:		Cell or local phone #		

in the **PAST YEAR**, have you experienced..... Y N if YES, explain with dates:

1	any injury requiring you to miss more than one practice or game?			
2	any injury requiring physical therapy or other treatment?			
3	any concussion or head injury?			
4	any burner/stinger or neck injury?			
5	any surgery or operation for any reason?			
6	any hospital admission (overnight) for any reason?			
7	any illness or medical condition lasting longer than one week?			
8	any heat exhaustion or heat stroke?			
9	Have you been advised to be on any medication on a regular basis?			name:
10	any NEW allergies to medications, foods, insects, etc.			
11	any chest pain or severe shortness of breath with exertion?			
12	any coughing or wheezing with exertion?			
13	any irregular heartbeat?			
14	any bone or joint pains not related to injury?			
15	any frequent or severe headaches?			
16	abdominal pains?			
17	skin problems?			
18	unexplained weight change?			
19	Do you currently have any incompletely healed injury?			
20	Have you started using any special equipment? (pads, braces, orthotics)			
21	What is your current conditioning status?			
22	<i>females only:</i> any changes in menstrual cycle?			
23	Do you have anything you wish to discuss with a trainer or healthcare provider?			

The questions on this form have been answered completely and truthfully to the best of my knowledge.

Student Signature

Date

