Cuthbertson High School
Athletic Training Department

Sport(s) ________________________ Date _____________

Medical History

________________________________ ________________________________ _____________________________
(Last Name) (First Name) (Middle Name)

Birth Date: ________________________ Sex: ☐ Male ☐ Female

Address: _______________________________________ City: _________________ State: _______ Zip: ___________

Parent/Guardian Name: ____ Home Phone: ________________

Employer's Name: ______________________________ Work Phone: ________________ Cell Phone: ______________

Emergency Contact ____________________________ Relationship: ____________________ Phone: _____________

General Health

1. Has athlete ever been hospitalized for any reason? ☐ Yes ☐ No
2. Has athlete ever had a major injury/illness? ☐ Yes ☐ No
3. Has athlete had any history of being knocked unconscious or had a concussion while playing sports or any other occasion? ☐ Yes ☐ No
4. Has athlete ever had chest pain during exertion? ☐ Yes ☐ No
5. Has athlete ever passed out or felt extremely dizzy during exercise? ☐ Yes ☐ No
6. Is there a family history of sudden death during exercise or hard work? ☐ Yes ☐ No
7. Has athlete ever experienced an episode during/after exercise where your heart was "racing" or beating abnormally? ☐ Yes ☐ No
8. Does athlete have problems exercising in the heat? (Cramping, Heat Exhaustion, Heat Stroke) ☐ Yes ☐ No
9. Has athlete ever missed more than 3 days of practice due to any health problems listed above? ☐ Yes ☐ No
10. Has athlete ever required surgery due to any medical illness or injury listed above? ☐ Yes ☐ No
11. Does athlete have only one of a normally paired organ? (eye, kidney, testicle, ovary, etc.) ☐ Yes ☐ No
12. Has athlete ever passed blood in urine? ☐ Yes ☐ No
13. Has athlete had mononucleosis within the past year? ☐ Yes ☐ No
14. Has athlete ever been treated for anemia? ☐ Yes ☐ No
15. Does athlete have a medical illness or injury (past/present) which we should know about for his/her own safety? ☐ Yes ☐ No
16. Is athlete's tetanus booster current? Date of last booster ______________ ☐ Yes ☐ No
17. Ladies only – Do you have any menstrual problems or irregularities? ☐ Yes ☐ No
18. Has athlete ever had or does he/she now have any of the following?

Heart Murmur	☐ Yes ☐ No	Ear Infection	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Dental Trouble	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Dizziness/Fainting	☐ Yes ☐ No	Sight Loss	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Severe Flu	☐ Yes ☐ No	Measles	☐ Yes ☐ No
Hernia	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	STD	☐ Yes ☐ No
Hay Fever	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Kidney Stone	☐ Yes ☐ No
Sinus Trouble	☐ Yes ☐ No	Hearing Loss	☐ Yes ☐ No	Gallbladder Trouble	☐ Yes ☐ No
HIV/ARC/AIDS	☐ Yes ☐ No	Cancer/Tumors	☐ Yes ☐ No	Bulemia	☐ Yes ☐ No
Sickle Cell	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No

Skin Disease	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Mumps	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	Anorexia	☐ Yes ☐ No
Stomach Ulcer	☐ Yes ☐ No	Mental Disorder	☐ Yes ☐ No	Alcohol/Drug Addiction	☐ Yes ☐ No

19. Does athlete normally wear eye correction while participating in sports? ☐ Yes ☐ No
☐ Glasses ☐ Extended Wear ☐ Lens Material ☐ Frame Material ☐ Soft Contacts

Explanation of injury or condition, specific body part involved, length of problem, etc. Be specific.

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Orthopedic Problems

1. Has athlete ever had any history of neck injuries? ☐ Yes ☐ No
   - Date: ______________
   - Cause: ____________________________
   - Treatment Given: ____
2. Does athlete have any history of "burners"/stingers", numbness or weakness in the neck, shoulder, arm or hand. ☐ Yes ☐ No
   - Date: ______________
   - Cause: ____________________________
   - Treatment Given: ____
3. Does athlete have any history of back pain or back injury? ☐ Yes ☐ No
   - Date: ______________
   - Cause: ____________________________
   - Treatment Given: ____
4. Has athlete ever been diagnosed as having scoliosis? ☐ Yes ☐ No
   - Date: ______________
   - Cause: ____________________________
   - Treatment Given: ____
5. Has athlete ever had a shoulder injury? ☐ Yes ☐ No
   - A. Shoulder dislocation or subluxation ☐ Yes ☐ No
     - Which Shoulder: ________________________
     - Date: ______________
     - Cause: ________________________________
     - Treatment Given: ____
   - B. Shoulder Separation (AC or SC joints?) ☐ Yes ☐ No
     - Which Shoulder: ________________________
     - Date: ______________
     - Cause: ________________________________
     - Treatment Given: ____
   - C. Rotator Cuff, Tendonitis, Bursitis, etc. ☐ Yes ☐ No
     - Which Shoulder: ________________________
     - Date: ______________
     - Cause: ________________________________
     - Treatment Given: ____

6. Has athlete ever had a knee injury? ☐ Yes ☐ No

A. Meniscus (cartilage) ☐ Yes ☐ No

Which Knee: ______________________________

Medial (inside) or Lateral (outside)

Date: ________________

Cause: ____________________________________

Treatment Given ____

B. Ligament Sprain ☐ Yes ☐ No

Which Knee: ______________________________

Date: _______________

Cause: ____________________________________

Treatment Given: ____

C. Tendonitis, Bursitis or Chondromalacia (patellofemoral pain) ☐ Yes ☐ No

Which Knee: ______________________________

Date: _______________

Cause: ____________________________________

Treatment Given: ____

D. Dislocation of Patella (knee cap) ☐ Yes ☐ No

Which Knee: ______________________________

Date: _______________

Cause: ____________________________________

Treatment: ____

E. Has athlete ever experienced an episode of:

Locking ☐ Yes ☐ No

Giving Way ☐ Yes ☐ No

Popping ☐ Yes ☐ No

Date: _______________

Cause: ____________________________________

Treatment: ____

F. Does athlete wear a knee brace? ☐ Yes ☐ No

Type: _____________________________________

Purpose: ___________________________________

Which Knee: _______________________________

7. Has athlete ever had an ankle injury? ☐ Yes ☐ No

A. Ligament Sprain ☐ Yes ☐ No

Which Ankle? ______________________________

Lateral (outside) or Medial (inside)

Date: ________________

Cause: ____________________________________

Severity and Treatment ____

B. Achilles Tendon Injury (including tendonitis) ☐ Yes ☐ No

Which Ankle? ______________________________

Date: ________________

Cause: ____________________________________

Treatment: ____

C. Ankle or Lower Leg Fracture/Break ☐ Yes ☐ No

Which Ankle/Specific bone? ____________________________

Date: ________________

Cause: ____________________________________

Treatment: ____

8. Has athlete ever had a foot injury? ☐ Yes ☐ No

Which Foot? ______________________

Date: __________

Treatment: ______________________________________

Type of Injury: ______________________

Cause: ____

9. Has athlete ever had a hip injury? ☐ Yes ☐ No

Which Hip? ______________________

Date: __________

Cause: ____

Treatment: ______________________________________

10. Has athlete ever had an elbow, arm, wrist or hand injury? ☐ Yes ☐ No

Which side? ______________________

Date: __________

Specific Details: ____________________

Cause: ____

Treatment: ______________________________________

11. Has athlete ever had an orthopedic injury that required him/her to miss more than 3 days of practice (not noted above)? (ex. Muscle strains or tears, etc.) ☐ Yes ☐ No

Type: ________________________

Body Part: ______________________

Date: __________

Cause: ____

Treatment: ______________________________________

12. Has athlete ever required surgery due to an orthopedic injury? ☐ Yes ☐ No

Date: __________

Body Part: ______________________

Cause: ____

Surgeon: ______________________

13. Does athlete use corrective orthotics? ☐ Yes ☐ No

14. Does athlete use any kind of a brace? ☐ Yes ☐ No

If "yes", where worn and for what purpose? ______________________

15. Does athlete require any regular taping or special bracing for athletic participation? ☐ Yes ☐ No

If "yes", please explain what part and why. ______________________

16. Does athlete have any orthopedic problems past or present which we should know about for his/her own safety? ☐ Yes ☐ No

Describe: ____

____

MEDICATIONS

Does athlete require medication on a daily or episodic basis? (Insulin, asthma, birth Control pills, etc.) ☐ Yes ☐ No

If "yes", what medications: ____________________

For what condition: ____________________________________

Dosage and how often taken________________________________

* If athlete is asthmatic, please provide a 2nd inhaler for the athletic trainer or coach to have available as a spare in the medical kit.

ALLERGIES

Is athlete allergic to any medication/drug, insect sting or food? ☐ Yes ☐ No

If "yes", what? ______________________________

How severe a reaction? ______________________________

Do you carry your own sting kit/epipen? ☐ Yes ☐ No

*If athlete has a known insect sting type allergy that may produce anaphylaxis, they must have with them/provide for us a sting kit to be used in an emergency.

The above statements are answered honestly and completely about my child to the best of my knowledge.

Parent/Guardian Signature ______________________________ Date ______________

Family Physician ______________________________ Phone ______________

Address ______________________________