

## Loras College Athletic Training Department Pre-Participation Medical History

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Sport: \_\_\_\_\_

Parent's Address: \_\_\_\_\_ Parent's Telephone: \_\_\_\_\_

**Explain "Yes" Answers:**

	<b><u>YES</u></b>	<b><u>NO</u></b>
1. Have you ever been hospitalized?	_____	_____
2. Have you ever had surgery?	_____	_____
3. Are you presently taking any medications or pills?	_____	_____
4. Do you have any allergies (medications, insects, or foods)?	_____	_____
5. Have you ever passed out during or after exercise?	_____	_____
6. Have you ever been dizzy during or after exercise?	_____	_____
7. Have you ever had chest pain during or after exercise?	_____	_____
8. Have you ever had high blood pressure?	_____	_____
9. Have you ever had a positive sickle cell trait test?	_____	_____
10. Have you ever been told that you have a heart murmur?	_____	_____
11. Has anyone in your family died of heart problems or a sudden death before age 50?	_____	_____
12. Do you have any skin problems (itching, rashes, acne)?	_____	_____
13. Have you ever had a head injury?	_____	_____
14. Have you ever been knocked out or unconscious?	_____	_____
15. Have you ever had a seizure?	_____	_____
16. Have you ever had a stinger, burner, or pinched nerve?	_____	_____
17. Have you ever had heat or muscle cramps?	_____	_____
18. Do you have trouble breathing, cough during or after activity, or have asthma?	_____	_____
19. Do you use any special equipment (pads, braces, mouth or eye guards, etc.)?	_____	_____
20. Have you had any problems with your eyes or vision?	_____	_____
21. Do you wear glasses or contacts or protective eye wear?	_____	_____
22. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?	_____	_____
<input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Chest <input type="checkbox"/> Hip <input type="checkbox"/> Forearm <input type="checkbox"/> Shin/calf <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Ankle/foot		
23. Have you had any other medical problems (mono, diabetes, loss of paired organ, etc.)?	_____	_____
24. Have you had a medical problem or injury since your last evaluation?	_____	_____
25. When was your last tetanus shot? _____		
26. When was your last measles immunization? _____		
27. When was your first menstrual period? _____		
28. When was your last menstrual period? _____		
29. When was your longest time between periods last year? _____		

**Please explain any "yes" answers:**

---



---



---



---

**I hereby state that, to the best of my knowledge, my answers to the above questions are correct.**

Signature of Athlete: \_\_\_\_\_ Date: \_\_\_\_\_