

# WAKE FOREST UNIVERSITY SPORTS MEDICINE

## ANNUAL ATHLETIC HEALTH HISTORY UPDATE 2008-2009

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SEX: M F  
 SPORT: \_\_\_\_\_ CLASS: FRSH SOPH JR SR 5<sup>th</sup> YR SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 HOME ADDRESS: \_\_\_\_\_  
 HOME TELEPHONE: \_\_\_\_\_ CELL TELEPHONE: \_\_\_\_\_  
 EMERGENCY CONTACT: \_\_\_\_\_ EMERGENCY TELEPHONE: \_\_\_\_\_

<b>MEDICAL HISTORY:</b> In the past year, have you had, or do you now have:			Explain any "YES" answers:
ASTHMA / BREATHING DIFFICULTY / COUGH WITH EXERCISE?	NO	YES	
ANY CHIPPED OR LOOSE TEETH?	NO	YES	
ANY TYPE OF EYE TROUBLE?	NO	YES	
HEAT-RELATED ILLNESS / SEVERE CRAMPS / PASSING OUT?	NO	YES	
RECURRENT HEADACHES?	NO	YES	
ANOREXIA / BULIMIA / EATING DISORDER?	NO	YES	
ABDOMINAL PAIN / NAUSEA / VOMITING / WEIGHT LOSS?	NO	YES	
MONONUCLEOSIS?	NO	YES	
CHEST PAIN WITH EXERCISE?	NO	YES	
LIGHTHEADEDNESS / DIZZINESS / FAINTING WITH EXERCISE?	NO	YES	
RACING OF YOUR HEART / SKIPPED BEATS?	NO	YES	
DO YOU TIRE MORE QUICKLY THAN YOUR TEAMMATES?	NO	YES	
HAVE YOU BEEN HOSPITALIZED?	NO	YES	
HAVE YOU EVER HAD A STRESS FRACTURE?	NO	YES	
HAVE YOU HAD ANY SURGERY?	NO	YES	
ARE YOU TAKING <i>ANY</i> PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS?	NO	YES	
HAVE YOU HAD ANY ALLERGIC REACTIONS TO MEDICATION(S) OR INSECTS?	NO	YES	
IS ANY DOCTOR PRESENTLY TREATING YOU FOR ANY DISORDER?	NO	YES	
<b>FEMALE ATHLETES ONLY:</b>			
WHEN DID YOUR LAST MENSTRUAL PERIOD BEGIN?			
WHAT WAS THE LONGEST TIME BETWEEN YOUR PERIODS IN THE LAST YEAR?			
HAVE YOU EVER BEEN ON BIRTH CONTROL (HORMONE) PILLS OR INJECTIONS?	NO	YES	

<b>INJURY HISTORY:</b> In the past year, have you had an injury of:		SIDE	DATE:	Current Problem?	Describe:
HEAD (concussion - "knocked out", surgery, hospitalization, other)	NO	YES	Lt. Rt.	N Y	
FACE (fracture, eye injury, ear problem, broken nose - deviated septum, other)	NO	YES	Lt. Rt.	N Y	
NECK (strain, fracture, "stinger - burner", surgery, other)	NO	YES	Lt. Rt.	N Y	
SHOULDER (dislocation, separation, rotator cuff injury, tendinitis, surgery, other)	NO	YES	Lt. Rt.	N Y	
ELBOW (joint sprain, muscle strain, fracture, tendinitis, dislocation, surgery, other)	NO	YES	Lt. Rt.	N Y	
ARM (joint sprain, muscle strain, fracture, tendinitis, dislocation, surgery, other)	NO	YES	Lt. Rt.	N Y	
WRIST / THUMB / HAND (sprain, fracture, tendinitis, surgery, other)	NO	YES	Lt. Rt.	N Y	
FINGER(S) (sprain, fracture, surgery, other)	NO	YES	Lt. Rt.	N Y	
CHEST (lung injury, heart injury, other)	NO	YES	Lt. Rt.	N Y	
ABDOMEN (kidney injury, spleen injury, liver injury, other)	NO	YES	Lt. Rt.	N Y	
GENITALIA (groin, testicle - ovary, other)	NO	YES	Lt. Rt.	N Y	
BACK (strain, chronic pain, slipped disc, surgery, other)	NO	YES	Lt. Rt.	N Y	
HIP / THIGH (fracture, muscle strain, calcium deposit, surgery, other)	NO	YES	Lt. Rt.	N Y	
KNEE (sprain, cartilage, pain, bursitis, tendinitis, surgery, other)	NO	YES	Lt. Rt.	N Y	
LOWER LEG (sprain, fracture, surgery, other)	NO	YES	Lt. Rt.	N Y	
ANKLE (sprain, fracture, tendinitis, other)	NO	YES	Lt. Rt.	N Y	
FOOT (sprain, fracture, plantar fasciitis - heel spur, surgery, other)	NO	YES	Lt. Rt.	N Y	
TOE(S) (fracture, surgery, other)	NO	YES	Lt. Rt.	N Y	

(over)

<b>GENERAL INFORMATION:</b>		If yes, explain:
Have you had an illness or injury in the last 12 months that has not been listed?	NO YES	
Have you used / Are you using any type of performance-enhancing substances or drugs?	NO YES	
Do you know of any health reason why you should not participate in the WFU intercollegiate athletic program at this time?	NO YES	

<b>DIET HISTORY:</b> Do you have / Have you ever had:		If yes, explain:
ANOREXIA / BULIMIA / EATING DISORDER?	NO YES	
DO YOU WANT TO WEIGH MORE / LESS THAN YOU DO?	NO YES	
HAVE YOU EVER INDUCED VOMITING TO CONTROL YOUR WEIGHT?	NO YES	
HAVE YOU EVER USED LAXATIVES, DIURETICS OR DIET PILLS FOR WEIGHT LOSS?	NO YES	
ARE YOU TAKING ANY VITAMINS, MINERALS, OR SUPPLEMENTS?	NO YES	
ARE THERE ANY FOOD GROUPS YOU CHOOSE NOT TO EAT (meat, dairy, etc.)?	NO YES	
<b>WHAT IS YOUR IDEAL WEIGHT?</b> _____		
WHAT FOODS (and supplements) HAVE YOU EATEN IN THE LAST 24 HOURS?		
Breakfast:		
Lunch:		
Dinner:		
Other:		

*Additional room if necessary:*

*Shaded boxes below to be completed by the sports medicine staff at Wake Forest University.*

Ht:	Wt:	BP: /	Pulse:	Comments:	MD Initial/Date:
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I, the undersigned, certify that the answers to the above questions are correct and true.

**ATHLETE'S SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_