Pre-Participation Medical History Questionnaire

Sam Houston State University

LAST NAME	FIRST NAME	MIDDLE INITIAL	STUDENT ID NUMBER
HEIGHT (inches)	WEIGHT (LBS)	DATE OF BIRTH	CELL PHONE
ADDRESS			HOME PHONE
CITY	STATE	ZIP CODE	E-MAIL ADDRESS
SPORT	TEAM STATUS (Check ONE) ☐Scholarship ☐Walk-On		CURRENT HIGH SCHOOL/JUNIOR COLLEGE/UNIVERSITY
ACADEMIC YEAR (CIRCLE ONE) ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ 5th Year			

EMERGENCY CONTACT INFORMATION

LAST NAME	FIRST NAME		CELL PHONE
ADDRESS			HOME PHONE
CITY	STATE	ZIP CODE	WORK PHONE

GENERAL MEDICAL HISTORY

Have you ever been admitted overnight to a hospital? ☐ Yes ☐ No If **yes,** for what condition? _____
Are you currently under the care of a physician? ☐ Yes ☐ No If **yes**, for what condition? _____
Have you ever experienced or been treated for a heat illness? ☐ Yes ☐ No Specify _____
Do you have allergy to any:

- Drug or medicine ☐ Yes ☐ No Specify _____
- Foods ☐ Yes ☐ No Specify _____
- Insects or Animals ☐ Yes ☐ No Specify _____
- Plants, grasses, pollens, dust or environmental factors ☐ Yes ☐ No Specify _____
- Latex, iodine, tape, or other allergies ☐ Yes ☐ No Specify _____

Has a physician ever told you that you have had any of the following medical problems? (Check all that apply)

☐ Nose Fracture	☐ Heart Abnormalities	☐ Hernia
☐ Hearing Defect	☐ Cancer	☐ Arthritis
☐ Recurrent Ear Infections	☐ Tumor, Growth or Cyst	☐ Marfan Syndrome
☐ Repeated Sinus Infections	☐ Mononucleosis (Last 4 Weeks)	☐ Leukemia
☐ Meningitis	☐ Kidney Injury/Illness	☐ Thyroid Disease
☐ Rheumatic Fever	☐ Injury to Liver or Spleen	☐ Diabetes
☐ Epilepsy or Seizers	☐ Jaundice/ Hepatitis	☐ Bowel Disease
☐ Sickle Cell Anemia/Carrier/Trait	☐ HIV	☐ Other Blood Disorders
☐ Anemia	☐ Iron Deficiency	☐ Frequent Urinary Infection
☐ Blood Clot or Embolism	☐ Stomach or Intestinal Ulcer	☐ Abnormal Clotting Disorder

Please list any medications you are currently taking _____

SURGICAL MEDICAL HISTORY

Have you had surgeries to any of the following?

Eyes	☐ Yes	☐ No	Date_____	If yes, for what condition?_____
Ears, Nose, Throat	☐ Yes	☐ No	Date_____	If yes, for what condition?_____
Heart	☐ Yes	☐ No	Date_____	If yes, for what condition?_____
Lungs	☐ Yes	☐ No	Date_____	If yes, for what condition?_____
Stomach/Bowels	☐ Yes	☐ No	Date_____	If yes, for what condition?_____
Kidneys	☐ Yes	☐ No	Date_____	If yes, for what condition?_____
Liver/Spleen	☐ Yes	☐ No	Date_____	If yes, for what condition?_____

CARDIO_RESPIRATORY MEDICAL HISTORY

Have you ever been told you have a heart murmur?	☐ Yes	☐ No
Have you ever had an abnormal racing of the heart or skipped beats?	☐ Yes	☐ No
Has anyone in your family died of a heart problem or sudden death before the age of 50?	☐ Yes	☐ No
Has anyone in your family died of a heart attack or had heart cauterization before the age of 50?	☐ Yes	☐ No
Have you ever been told by a physician that you have high blood pressure?	☐ Yes	☐ No
Are you currently taking any medication for high blood pressure?	☐ Yes	☐ No
Have you ever undergone any cardiac testing (EKG, echocardiogram, stress test, tilt table, holter, cardiac cath)?	☐ Yes	☐ No
During or after exercise have you ever experienced the following?	☐ Yes	☐ No
Dizziness or lightheadedness	☐ Yes	☐ No
Pass out	☐ Yes	☐ No
Chest pain, discomfort, or tightness	☐ Yes	☐ No
Found it more difficult to breath than usual	☐ Yes	☐ No
Have you ever been diagnosed with asthma?	☐ Yes	☐ No
Are you currently taking any medications for asthma?	☐ Yes	☐ No If **yes**, Please list _____

HEAD AND NEUROLOGICAL MEDICAL HISTORY

Have you ever had a concussion (Injury to the head)with or without loss of consciousness? ☐ Yes ☐ No

If **yes**
- How many concussions? _____
- How much time did you miss from athletics? _____
- Who diagnosed your concussion? ☐ Athletic Trainer ☐ Physician ☐ Coach ☐Other
- Did you have any diagnostic testing done? ☐ Yes ☐ No Specify _____
- Have you ever been knocked unconscious? ☐ Yes ☐ No If **yes**, how many times?_____

Have you ever had numbness, tingling, or weakness in your

Shoulders, Arms, or hands	☐ Yes	☐ No
Buttocks	☐ Yes	☐ No
Legs or Feet	☐ Yes	☐ No

Have you ever had a burner / Stinger (an injury that causes burning pain and numbness down arm and hand)? ☐ Yes ☐ No

If yes, did it result in any loss of time from practice or games? ☐ Yes ☐ No If **yes**, How much time?_____

Have you ever had a seizure? ☐ Yes ☐ No

Do you experience migraine headaches? ☐ Yes ☐ No If **yes**, what medications are used to help? _____

VISION MEDICAL HISTORY

Have you ever had a serious eye injury?	☐ Yes	☐ No	Specify _____
Do you wear contacts or glasses?	☐ Yes	☐ No	If **yes** (please circle one) Contacts Glasses Both
Do you currently have two normal eyes?	☐ Yes	☐ No	
Do you wear protective eyewear for your sport?	☐ Yes	☐ No	
Have you ever had any problems with your eyes or vision?	☐ Yes	☐ No	

NUTRITIONAL HISTORY

What is your desired body weight? _____

When were you last at that weight? ☐ Never ☐ < 6 months ☐ 6 months – 1 year ☐ 1-2 years
☐ 2-3 years ☐ 3-4 years ☐ 4-5 years ☐ Other

What is your lowest and highest weight in the past year? Lowest _____ Highest _____

Are you currently taking any action towards your weight?

☐ Trying to lose weight ☐ Trying to gain weight ☐ Gain lean body mass

☐ Trying to stay the same weight ☐ Not doing anything about my weight

☐ I am trying to change my body shape to be more muscular and/or have less fat but cot concerned about my weight?

Do you think your performance would improve if you lost weight or gained weight? ☐ Yes ☐ No

Do you have any goals for body composition? ☐ Yes ☐ No

If yes, which ones? (check all that apply) ☐ Gain Lean mass/weight ☐ Decrease body fat ☐ Lose weight
☐ Maintain current body weight ☐ None

How would you describe your eating habits? _____

Do you frequently skip meals (at least one time per week)? ☐ Yes ☐ No

If yes, please explain _____

What percent of your day do you think about food? ☐ 0-15 ☐ 15-25 ☐ 25-50 ☐ 50-75 ☐ 75-100

Do you avoid any of the following foods? (Check all that apply)

☐ Red Heat ☐ Dairy (milk, cheese) ☐ Grains (pasta, rice) ☐ Fast Food

☐ Poultry ☐ Vegetables ☐ Sweets (candy, desserts, etc) ☐ Other (please specify)

☐ Fish ☐ Fruits ☐ Alcohol _____

☐ Breads ☐ Fried Foods ☐ Fats/Oils (butter, mayo, etc)

Briefly explain why you avoid these foods: _____

Are you a vegetarian? ☐ Yes ☐ No

Are you a vegan? ☐ Yes ☐ No

Have you been diagnosed by a medical professional with a food allergy or sensitivity? ☐ Yes ☐ No

If yes, please describe _____

Do you eat three or more servings of calcium-rich foods every day? ☐ Yes ☐ No

(Examples of one serving = 1 cup of milk, or calcium-fortified orange juice, 0.5 oz od cheese, 1 serving of calcium fortified cereal that supplies 30% or more of daily value for calcium).

If no, do you take calcium supplements? ☐ Yes ☐ No

Do you drink 5 or more cups of coffee, tea and/or soda daily? ☐ Yes ☐ No

Do you consume any supplements? ☐ Yes ☐ No

(i.e. multivitamins, protein powders, fish oil, pre/post workout)

If yes, please describe _____

How many times a year do you intentionally change your weight for your sport? _____

Have your coaches ever asked you to change your weight for your sport? ☐ Yes ☐ No

If yes, please explain _____

Overall, how satisfied are you with your physical appearance of your body?

☐ Very Satisfied ☐ Somewhat Satisfied ☐ Somewhat Dissatisfied ☐ Very Dissatisfied

Overall, how satisfied are you with the physical performance of your body?

☐ Very Satisfied ☐ Somewhat Satisfied ☐ Somewhat Dissatisfied ☐ Very Dissatisfied

How easy or difficult is it for you to maintain your in-season weight?

☐ Very Easy ☐ Somewhat Easy ☐ Somewhat Dissatisfied ☐ Very difficult

How often do you eat beyond feeling full?

☐ Never ☐ Rarely (a few times) ☐ Occasionally (1-2 times/ per month) ☐ Frequently (weekly or more)

How often do you feel out of control when you eat?

☐ Never ☐ Rarely (a few times) ☐ Occasionally (1-2 times/ per month) ☐ Frequently (weekly or more)

Have you tried any of the following in the past year? (check all that apply)

☐ fad diets ☐ Restriction of fat ☐Diuretics or water pills ☐Exercise in addition to required lifts for sport

☐ Diet pill ☐ Restriction of carbs ☐ Skipping meals ☐ Restriction of calories

☐ Laxatives ☐Self-induced vomiting

Do you make an effort to modify your caloric intake when you don't exercise? ☐ Yes, I try to eat less

☐ Yes, I try to eat more

☐ No, I eat about the same

Would you like to meet with a nutritionist upon your arrival to campus? ☐ Yes ☐ No

FEMALE MEDICAL HISTORY

At what approximate age did your menstrual period begin? _____

When was your last period? _____

Describe a typical (for you) menstrual cycle (i.e. length between periods, number of days you have bleeding, and heaviness of flow):

_____

_____

How many periods have you had in the last year? _____

Since starting your cycle have you ever gone 3 months without having a period? ☐ Yes ☐ No

If **yes**, how many months did you lack a period? _____

Are you currently taking birth control pills or other hormone replacement medication? ☐ Yes ☐ No

If **yes**, how long have you been on birth control pills? _____

If **yes**, did you start on these for the reason of regulating your cycle? ☐ Yes ☐ No

MALE MEDICAL HISTORY

Do you currently have two normal testicles? ☐ Yes ☐ No

MENTAL HEALTH HISTORY

How often do you experience the following emotions?

Sadness or Depressed Feeling	☐ Never	☐ A few times per year	☐ Monthly	☐ Weekly	☐ Daily
Fear, Worry, or Anxiety	☐ Never	☐ A few times per year	☐ Monthly	☐ Weekly	☐ Daily
Anger or Short Temper	☐ Never	☐ A few times per year	☐ Monthly	☐ Weekly	☐ Daily
Low Energy/Fatigue	☐ Never	☐ A few times per year	☐ Monthly	☐ Weekly	☐ Daily
Poor Feelings about Self	☐ Never	☐ A few times per year	☐ Monthly	☐ Weekly	☐ Daily
Loneliness or Isolation	☐ Never	☐ A few times per year	☐ Monthly	☐ Weekly	☐ Daily
Difficulty Managing Substance Use	☐ Never	☐ A few times per year	☐ Monthly	☐ Weekly	☐ Daily
Struggles with Academic Performance	☐ Never	☐ A few times per year	☐ Monthly	☐ Weekly	☐ Daily

Have you ever been diagnosed with a learning disability? ☐ Yes ☐ No

Do you have or have you ever been diagnosed and/or treated for attention deficit or hyperactivity? ☐ Yes ☐ No

Do you have or have you ever been diagnosed and/or treated for substance or alcohol abuse? ☐ Yes ☐ No

Do you have or have you ever been diagnosed and/or treated with an eating disorder? ☐ Yes ☐ No

Do you have or have you ever been treated for a psychiatric condition (depression, anxiety, etc.)? ☐ Yes ☐ No

Are you currently taking medication for any of the above conditions? ☐ Yes ☐ No Medication _____

Do you have any other mental health issues which require the services of a mental health provider? ☐ Yes ☐ No

Would you like to meet with a mental health counselor upon your arrival to campus? ☐ Yes ☐ No

ORTHOPEDIC HEALTH HISTORY

Do you currently use for practice or competition?

Brace, splint or sleeve ☐ Yes ☐ No If yes, please specify _____

Special protective device/padding ☐ Yes ☐ No If yes, please specify _____

Orthotics (custom shoe inserts) ☐ Yes ☐ No If yes, please specify _____

Have you ever received a corticosteroid (i.e. cortisone) injection into a tendon, bursa or joint for injury or pain? ☐ Yes ☐ No

Have you ever had or do you currently have an injury or problem of the following (if you don't know, check "No")?

NECK

	Yes	No	Side: Right	Side: Left	X-Rays: Yes	X-Rays: No	MRI: Yes	MRI: No	Surgery: Yes	Surgery: No	Healed: Yes	Healed: No	Time Missed: None	Time Missed: <1 week	Time Missed: 1-3 weeks	Time Missed: >3 weeks
Disc (Bulge/Herniation)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Traumatic Fracture	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stress Fracture	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Whiplash	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Facet Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stingers/Burners	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Muscle Strain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If **yes** to any, please provide specifics of any injuries, surgeries, or ongoing problems listed above.

SPINE/BACK

	Yes	No	Side: Right	Side: Left	X-Rays: Yes	X-Rays: No	MRI: Yes	MRI: No	Surgery: Yes	Surgery: No	Healed: Yes	Healed: No	Time Missed: None	Time Missed: <1 week	Time Missed: 1-3 weeks	Time Missed: >3 weeks
Back Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Back Stiffness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Back Spasms	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Spondylolysis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Disc (Bulge/Herniation)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sacroiliac Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sciatica	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Traumatic Fracture	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stress Fracture	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Facet Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Muscle Strain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If **yes** to any, please provide specifics of any injuries, surgeries, or ongoing problems listed above.

SHOULDER/CLAVICLE

	Yes	No	Side: Right	Side: Left	X-Rays: Yes	X-Rays: No	MRI: Yes	MRI: No	Surgery: Yes	Surgery: No	Healed: Yes	Healed: No	Time Missed: None	Time Missed: <1 week	Time Missed: 1-3 weeks	Time Missed: >3 weeks
Fracture	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bursitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Acromioclavicular Sprain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Rotator Cuff Tendinitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Shoulder Impingement	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dislocation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Subluxation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Muscle Strain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If **yes** to any, please provide specifics of any injuries, surgeries, or ongoing problems listed above.

UPPER ARM/FOREARM

	Yes	No	Side: Right	Side: Left	X-Rays: Yes	X-Rays: No	MRI: Yes	MRI: No	Surgery: Yes	Surgery: No	Healed: Yes	Healed: No	Time Missed: None	Time Missed: <1 week	Time Missed: 1-3 weeks	Time Missed: >3 weeks
Fracture	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Muscle Strain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tendon Injury	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If **yes** to any, please provide specifics of any injuries, surgeries, or ongoing problems listed above.

ELBOW

	Yes	No	Side: Right	Side: Left	X-Rays: Yes	X-Rays: No	MRI: Yes	MRI: No	Surgery: Yes	Surgery: No	Healed: Yes	Healed: No	Time Missed: None	Time Missed: <1 week	Time Missed: 1-3 weeks	Time Missed: >3 weeks
Fracture	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dislocation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ligament Injury/Sprain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tennis/Golfer's Elbow	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bursitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If **yes** to any, please provide specifics of any injuries, surgeries, or ongoing problems listed above.

HAND/WRIST/FINGERS

	Yes	No	Side: Right	Side: Left	X-Rays: Yes	X-Rays: No	MRI: Yes	MRI: No	Surgery: Yes	Surgery: No	Healed: Yes	Healed: No	Time Missed: None	Time Missed: <1 week	Time Missed: 1-3 weeks	Time Missed: >3 weeks
Fracture	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stress Fracture	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dislocation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ligament Injury/Sprain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tendon Injury	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tendinitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If **yes** to any, please provide specifics of any injuries, surgeries, or ongoing problems listed above.

HIP/PELVIS

	Yes	No	Side: Right	Side: Left	X-Rays: Yes	X-Rays: No	MRI: Yes	MRI: No	Surgery: Yes	Surgery: No	Healed: Yes	Healed: No	Time Missed: None	Time Missed: <1 week	Time Missed: 1-3 weeks	Time Missed: >3 weeks
Fracture	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stress Fracture	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dislocation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Groin Strain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bursitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tendinitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Contusion/Hip Pointer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If **yes** to any, please provide specifics of any injuries, surgeries, or ongoing problems listed above.

THIGH			Side		X-Rays		MRI		Surgery		Healed		Time Missed			
	Yes	No	Right	Left	Yes	No	Yes	No	Yes	No	Yes	No	None	<1 week	1-3 weeks	>3 weeks
Fracture	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stress Fracture	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tendinitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bursitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hamstring Strain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Quadriceps Strain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Severe Contusion	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If **yes** to any, please provide specifics of any injuries, surgeries, or ongoing problems listed above.

KNEE			Side		X-Rays		MRI		Surgery		Healed		Time Missed			
	Yes	No	Right	Left	Yes	No	Yes	No	Yes	No	Yes	No	None	<1 week	1-3 weeks	>3 weeks
Fracture	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ACL Tear/Sprain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
PCL Tear/Sprain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
MCL Tear/Sprain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
LCL Tear/Sprain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Meniscus Injury	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Locking Knee	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dislocation (Patella)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Iliotibial Band Injury	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Swelling	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Unexplained Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tendinitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bursitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pain Around Knee Cap	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Feeling of "giving out"	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If **yes** to any, please provide specifics of any injuries, surgeries, or ongoing problems listed above.

LOWER LEG/SHIN			Side		X-Rays		MRI		Surgery		Healed		Time Missed			
	Yes	No	Right	Left	Yes	No	Yes	No	Yes	No	Yes	No	None	<1 week	1-3 weeks	>3 weeks
Fracture	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stress Fracture	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Muscle Strain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Compartment Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Shin Splints	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Achilles Tendinitis/Strain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If **yes** to any, please provide specifics of any injuries, surgeries, or ongoing problems listed above.

ANKLE			Side		X-Rays		MRI		Surgery		Healed		Time Missed			
	Yes	No	Right	Left	Yes	No	Yes	No	Yes	No	Yes	No	None	<1 week	1-3 weeks	>3 weeks
Fracture	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stress Fracture	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sprain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tendinitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bursitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Instability	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bone chip in joint	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dislocation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If **yes** to any, please provide specifics of any injuries, surgeries, or ongoing problems listed above.

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FOOT/TOES			Side		X-Rays		MRI		Surgery		Healed		Time Missed			
	Yes	No	Right	Left	Yes	No	Yes	No	Yes	No	Yes	No	None	<1 week	1-3 weeks	>3 weeks
Fracture	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stress Fracture	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sprain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tendinitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bone Spur	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Plantar Fasciitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Flat Arches of Feet	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Turf Toe/Toe Sprain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dislocation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If **yes** to any, please provide specifics of any injuries, surgeries, or ongoing problems listed above.

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_____

Please list any additional medical problems the SHSU medical staff should be aware of:

_____

_____

_____

_____

This form will be reviewed by the team physician and athletic training staff and placed in your permanent medical file at Sam Houston State University. I understand that if I do not provide complete and accurate medical history information about myself it will negatively affect the medical care provided by the team physician and athletic training staff. By signing below, I agree that the information I have provided is complete, true and accurate to the best of my knowledge and I understand that Sam Houston State University and its employees and agents do not accept legal responsibility and will not be liable related to any medical conditions whose care might be affected by my withholding or providing misleading information.

_____ _____

Student-Athlete Signature Date