

NDSCS ATHLETE MEDICAL HISTORY
SPORT PARTICIPATING IN: _____
NAME: _____

CIRCLE THE APPROPRIATE ANSWER:

- YES / NO Have you ever been knocked out or experienced a concussion? If yes, how many? _____ Hospitalized? _____
- YES / NO Have you ever passed out? If yes, how long ago was the most recent occurrence? _____
- YES / NO Have you ever had a burner or stinger? If yes, how many? _____
- YES / NO Has your physical activity ever been limited due to a heart problem?
- YES / NO Have you ever been withheld from participation in a sport for medical reasons?
- YES / NO Do you wear glasses or contacts while playing?
- YES / NO Do you have any dead, missing, chipped, or broken teeth? If yes, how many? _____
- YES / NO Do you wear dental appliances? (Braces, dentures, bridges, ect.)
- YES / NO Have you had any injuries to the neck or back nerves, vertebrae, or disks in your back?
- YES / NO Have you had surgery on your neck or back?
- YES / NO Do you experience pain in the back? If yes, indicate frequency of occurrence. _____
- YES / NO Have you been told you injured the ligaments or cartilage of either knee?
- YES / NO Have you experienced a severe ankle sprain?
- YES / NO Have you had any fractures within the last two years? If yes, indicate location and date of occurrence.
- YES / NO Have you had any joint dislocations in the last two years? If yes, indicate location and date of occurrence.
- YES / NO Do you have a pin, screw, or plate somewhere in your body? If yes, indicate location of appliance.
- YES / NO Are you currently taking any medication? If so, list the drug(s) and strength: _____

YES / NO` Are you allergic to any medications? If so, list the drug: _____

DO YOU HAVE A HISTORY OF: (Explain "YES" answers in space below)

<u>RESPIRATORY</u>	YES	NO	<u>EMOTIONAL PROBLEMS</u>	YES	NO
Asthma	___	___	Anxiety	___	___
Colds, frequent	___	___	Depression	___	___
Dizziness	___	___	Mental Health	___	___
Shortness of Breath	___	___	Worry, often, severe	___	___
Sleeplessness	___	___	Have you received mental health services or been hospitalized for mental health reasons?	___	___
<u>CARDIOVASUCLAR</u>			<u>GASTROINTESTINAL</u>		
Heart Disease, Murmur	___	___	Colitis	___	___
High Blood Pressure	___	___	Diarrhea, frequent	___	___
Dizziness	___	___	Eating Problems	___	___
Palpitations	___	___	Ulcer, Stomach or other	___	___
<u>ABUSE</u>			<u>NEUROLOGICAL</u>		
Emotional	___	___	Convulsions	___	___
Physical	___	___	Epilepsy	___	___
Sexual	___	___	Head Injury/Unconscious	___	___
<u>EATING PROBLEMS</u>			Headache, often, severe		
Anorexia	___	___	Migraine Headache		
Binging	___	___			
Bulimia	___	___	<u>SENSORY</u>		
Diabetes	___	___	Ear Trouble, Hearing loss		
Dizziness	___	___	Eye Trouble		
Fainting/Blackouts	___	___			
Overweight	___	___			
Underweight	___	___			
Weight/Recent Gain	___	___			
Weight/Recent Loss	___	___			
Other?	___	___			

Are you now, or have you ever been treated

For an eating disorder? ___ ___ LIST DATES OF CARE: _____

CONTINUED...

<u>MENSTRUATION</u>	YES	NO
Irregular	___	___
Severe Cramps	___	___
Excessive Flow	___	___
Breast Lumps	___	___
Sexually Transmitted Disease	___	___
Menstrual History		
Last Period _____		
Length of Period _____		

<u>ALLERGIES</u>	YES	NO
List type of allergy _____		
Will you need any allergy desensitization therapy?	___	___

If yes, bring serum and schedule from physician.

OTHER

Learning Disability	___	___
Do you smoke?	___	___

EXPLAIN YES answers : _____

NORTH DAKOTA STATE COLLEGE OF SCIENCE ATHLETIC INFORMATION

RELEASE AUTHORIZATION

I hereby authorize NDSCS athletic coaches and Head Athletic Trainer to release information concerning my status including but not limited to attendance, attitude, dependability, homework, grades as well as any injury management or medical treatments deemed necessary or my general behavior to: my parent(s) or guardian(s).

This authorization is open only for the period of time that I am a member of a NDSCS athletic team.

Print Name

Date

Signature

ACKNOWLEDGE OF RISK AND CONSENT TO TREAT

I have completed and reviewed the Medical History and Physical Examination Form and affirm that it is true and correct to the best of my ability. I consent to participate in the following sport/s _____ which may include travel, those inherent health risks which athletes are predisposed to, possible catastrophic injury, or even death. I hereby grant permission to NDSCS to render and/or authorize preventative care, first aid, treatment, rehabilitation, and /or emergency treatment deemed reasonably necessary to protect my health and well being.

Athlete _____

Date _____