Labette Community College Medical Health History Form

Name: _____ Sport: _____ Todays Date: _____

Date of Birth: _____ Sex: M F Athletic Eligibility: Fr So

Home Address: _____

Home Telephone #: _____ Student-Athlete Cell Phone #: _____

Emergency Contact Information:

Name/s: _____ Relationship: _____

Telephone #'s: _____

Please read the following questions and answer as completely as you can.
Fully explain all "yes" responses. If you need additional room, please attach additional sheets.

Family Health History
Are any of the following conditions present in any full blood relative? (i.e.: mom, dad, sister, brother, grandparent, etc.)

Arrhythmias:	Yes	No	Hypertrophic Cardiomyopathy (HCM):	Yes	No
Blood Disease (Sickle Cell, Leukemia):	Yes	No	Long or Short QT Syndrome:	Yes	No
Diabetes:	Yes	No	Marfan Syndrome:	Yes	No
Epilepsy:	Yes	No	Seizures:	Yes	No
Heart Condition:	Yes	No	Sickle Cell Trait/Disease:	Yes	No
Heart Disease (Before Age 50):	Yes	No	Stroke:	Yes	No
Hemophilia:	Yes	No	Sudden Death (Before Age 50):	Yes	No
High Blood Pressure:	Yes	No	Tuberculosis:	Yes	No

If yes, please write their relation to you? _____
_____
_____

Medical and Orthopedic History
Please answer the following questions about the student-athlete's medical and orthopedic history.

Allergy History

1. Do you have an allergy to any medications? (i.e.: sulfa, aspirin, penicillin, etc.) If yes, what medications?	Yes No
2. Do you have any allergies to food? (i.e.: nuts, shellfish, etc.) If yes, what foods?	Yes No
3. Do you have an allergy to insect bites/stings? If yes, what insects?	Yes No
4. Do you have seasonal allergies that require medical treatment or medication?	Yes No
5. Are you allergic to anything not mentioned above? (i.e.: latex, adhesive tape, etc.) If yes, what?	Yes No
6. Does a Doctor or allergy require you to carry an epi-pen?	Yes No

Do you have or have you ever had?

Anemia:	Yes	No	Migraine Headaches:	Yes	No
Asthma:	Yes	No	Mononucleosis ("mono"):	Yes	No
Blood Clots:	Yes	No	Mumps:	Yes	No
Blood in Urine:	Yes	No	Muscular Disease:	Yes	No
Bowel Disease:	Yes	No	Organ Not Functional/Missing:	Yes	No
Cancer or Malignancy:	Yes	No	Organ Surgery:	Yes	No
Chemical Dependency:	Yes	No	Pleurisy:	Yes	No
Diabetes:	Yes	No	Pneumonia:	Yes	No
Eating Disorders:	Yes	No	Red Measles:	Yes	No
Epilepsy/Seizures:	Yes	No	Respiratory Infection:	Yes	No
Frequent Anxiety:	Yes	No	Rheumatic Fever:	Yes	No
Hearing Defect/Loss:	Yes	No	Rubella:	Yes	No
Heart Disease/Condition:	Yes	No	Sickle Cell Disease:	Yes	No
Heat Illness:	Yes	No	Skin Condition:	Yes	No
Hepatitis/Jaundice	Yes	No	Spleen Condition:	Yes	No
Hernia:	Yes	No	Staphylococcus/MRSA:	Yes	No
High/Low Blood Pressure:	Yes	No	Stomach Ulcer (Peptic):	Yes	No
Kidney Disease/Injury:	Yes	No	Stroke:	Yes	No
Kidney Stones:	Yes	No	Thyroid Disorder:	Yes	No
Marfan Syndrome:	Yes	No	Tuberculosis:	Yes	No
Measles:	Yes	No	Tumor, Growth, Cyst:	Yes	No

Please explain all "yes" responses: _____

_____

_____

_____

Heat Illness/Nerve/Cardiac

1. Have you ever had heat exhaustion, heat stroke, or "sunstroke"?	Yes	No
2. Have you had a pinched nerve, disk injury, or a burner/stinger?	Yes	No
3. Have you ever had numbness, tingling, or weakness in your arms, hands, legs, or feet?	Yes	No
4. Have you ever been unable to move your arms or legs after being hit or falling?	Yes	No
5. Have you ever felt dizzy, light-headed, or passed out during or after exercise?	Yes	No
6. Have you ever had discomfort, pain, or pressure in your chest while exercising?	Yes	No
7. Do you cough, wheeze, or have difficulty breathing during or after exercise?	Yes	No
8. Have you ever been seen by a Doctor for a heart related condition? If yes, when and for what? Physicians Name:	Yes	No
9. If you have answered yes to any of these questions, please explain below and list dates:		

Athletic Injuries

1.	Have you ever had an injury to one of the follow body parts that caused you to miss a week or more participation in your sport? Skull Neck Eyes Ears Nose Throat Mouth Teeth Abdomen Ribs Chest Back Spine Hip Groin Shoulder Upper Arm Elbow Forearm Wrist Hand Fingers Thigh Lower Leg Ankle Foot Toes Other: _____	Yes No
2.	Have you seen a Doctor or been hospitalized for the above circled body part/s?	Yes No
3.	Have you ever had a fracture, dislocation, or surgery on the above circled body part/s?	Yes No
4.	Have you gone to rehabilitation/physical therapy for the above circled body part/s?	Yes No
5.	Have you ever been advised to have a surgery not yet performed?	Yes No
6.	If you have answered yes to any of these questions, please explain in full detail below: Right or Left?	

Current Medication/s

1.	Are you currently taking any prescription medications? (This includes all pills, inhalers, injections, ointments etc. that a Doctor prescribes.)	Yes No

If yes, please list the name, dosage, and reason: _____
_____
_____
_____

2.	Are you currently taking any over-the-counter medications? [i.e.: supplements, vitamins, anti-inflammatories, pain medication, or any other medications (pills, inhalers, injections, ointments etc.) not listed above]	Yes No

If yes, please list the name, dosage, and reason: _____
_____
_____
_____
_____
_____

Concussion History

1. Have you ever had a concussion? If yes, how many? _____ Who diagnosed the concussion? _____ Date of the last concussion: _____ Date of the other concussions: _____ How long did it take for complete recovery (no symptoms)? _____	Yes No
2. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?	Yes No
3. Have you ever lost consciousness/knocked out due to a blow to the head? If yes, when?	Yes No
4. Have you ever been hospitalized due to a head injury? If yes, when?	Yes No

Miscellaneous

1. Has a Doctor ever denied or restricted your participation in sports for any reason?	Yes No
2. Do you use any special equipment (pads, braces, mouth guard, etc.)?	Yes No
3. Do you use an assistive or corrective device for vision or hearing during practices/games (i.e.: contact lenses, glasses, hearing aids, etc.)?	Yes No
4. Do you have any ongoing medical conditions?	Yes No
5. Do you currently have an injury that is not completely healed?	Yes No
6. Is there any reason you are not able to participate in athletics?	Yes No
7. Have you had any other medical, health, orthopedic, surgery, injury, or comments/concerns/problems that have not been mentioned on this form?	Yes No
8. Are there any additional health problems/concerns that you would like to discuss privately with the athletic trainer and/or team Doctor?	Yes No
9. If you have answered yes to any of these questions, please explain below and list dates:	

I, the undersigned, hereby acknowledge, affirm, and represent that all statements on the previous pages are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

Printed Name of Athlete: _____

Signature: _____ Date: _____

**Parent/Guardian Signature (only if under 18 years old): _____ Date: _____

Concussion Acknowledgement

What is a concussion?

- ***A brain injury that is caused by a blow to the head or body***
  - Causes can include hitting a hard surface such as the ground/floor, contact with another player, or being hit by a piece of equipment such as a ball
- It can range from mild to severe
- It can occur during practice or competition in ANY sport
- It is different for each athlete
- ***It can happen even if you do NOT lose consciousness/get knocked out***

What are the symptoms of a concussion?

- Balance Problems
- Blurred Vision
- Difficulty Concentrating
- Headaches
- Irritability
- Nausea/Vomiting
- Nervous or Anxious
- Ringing in the Ears
- Sadness
- Sensitivity to Light
- Sensitivity to Noise
- Slowed Reaction Time

What should I do if I think I have a concussion?

Don't hide it. Tell your athletic trainer if you or your teammate might have a concussion. Never ignore a blow to the head. Sports have injury timeouts and player substitutions so that you can get checked out.

Report it. Do not return to participation in a game, practice, or other activity with symptoms. The sooner you get checked out, the sooner you may be able to return to play.

Get checked out. Your athletic trainer or Team Doctor can tell you if you have had a concussion and when you are cleared to return to play. A concussion can affect your ability to perform everyday activities, your reaction time, balance, sleep, and classroom performance.

Take time to recover. If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a repeat concussion. In rare cases, repeat concussions can cause permanent brain damage and even death. Severe brain injury can change your whole life.

It's better to miss one game than the whole season.
When in doubt, get checked out.

Information From: NCAA Concussion Fact Sheet, Centers for Disease Control and Prevention, and the Kansas Sports Concussion Partnership

By signing the below, I state that I have read and understand the presented information, including signs and symptoms. I also confirm that I shall always report any suspecting concussions (of myself or others) to the Labette Community College athletic training staff.

Printed Name of Student - Athlete: _____

Signature: _____ Date: _____

**Parent/Guardian Signature (only if under 18 years old): _____ Date: _____