



- YES NO 7. Have you ever taken medication to regulate your BP? Medication \_\_\_\_\_ Date \_\_\_\_\_
- YES NO 8. Have you had a family member under 40 die suddenly from a cardiac condition? Relation \_\_\_\_\_
- YES NO 9. Have you ever had any of the following during exercise? (circle all that apply)  
 Dizziness Lightheaded Passed out  
 Chest pain Irregular heartbeat Palpitations  
 Explain \_\_\_\_\_
- YES NO 10. Have you ever experienced a seizure or been informed that you might have epilepsy? Date \_\_\_\_\_
- YES NO 11. If the answer to question 10 is yes, are your seizures controlled by medication?  
 Medication \_\_\_\_\_
- YES NO 12. Have you had hepatitis during the past five years? Give date \_\_\_\_\_
- YES NO 13. Have you ever been informed you have or been treated for diabetes?
- YES NO 14. If the answer to question 13 is yes, how is it regulated? Injections \_\_\_\_\_ times/day \_\_\_\_\_  
 Exercise \_\_\_\_\_ Diet \_\_\_\_\_
- YES NO 15. Have you ever been informed that you have an anemia? Date \_\_\_\_\_
- YES NO 16. Have you had any illness requiring bed rest of one week or longer during the past year?  
 Nature of the illness \_\_\_\_\_

**HEAD AND NECK**

- YES NO 17. Have you ever had a concussion (i.e. bell rung, ding)? Total number \_\_\_\_\_  
 How many concussions in the last five years? \_\_\_\_\_ Date(s) \_\_\_\_\_
- YES NO 18. Have you ever been knocked unconscious(as a result of concussion? How many times? \_\_\_\_\_  
 Date(s) \_\_\_\_\_
- YES NO 19. If the answer to 17 or 18 is yes, did you stay overnight in the hospital?  
 Details \_\_\_\_\_
- YES NO 20. Have you ever experienced seizures after a head injury? Date \_\_\_\_\_  
 Details \_\_\_\_\_
- YES NO 21. Have you ever had any of the following?  
 Strained neck \_\_\_\_\_ Date \_\_\_\_\_ Fractured neck \_\_\_\_\_ Date \_\_\_\_\_  
 Sprained neck \_\_\_\_\_ Date \_\_\_\_\_ Pinched nerve \_\_\_\_\_ Date \_\_\_\_\_  
 Whiplash \_\_\_\_\_ Date \_\_\_\_\_ Severe headaches \_\_\_\_\_ Date \_\_\_\_\_  
 Other \_\_\_\_\_ Date \_\_\_\_\_

**EYES AND DENTAL**

- YES NO 22. Do you have vision in both eyes? If no, give details \_\_\_\_\_  
 \_\_\_\_\_
- YES NO 23. Do you wear glasses? Regular \_\_\_\_\_ Safety lens or frames \_\_\_\_\_
- YES NO 24. Do you wear contact lenses? Hard \_\_\_\_\_ Soft \_\_\_\_\_
- YES NO 25. If the answer to question 23 or 24 is yes, do you wear them during athletic competition? Specify what you  
 wear during competition \_\_\_\_\_

YES NO 26. Do you wear any of the following dental appliances? (circle all that apply)  
 Permanent bridge          Permanent crown or jacket          Removable partial  
 Full plate                  Braces                  Other \_\_\_\_\_  
 Explain \_\_\_\_\_

YES NO 27. Do you have any dead teeth? \_\_\_\_\_

**BONES AND JOINTS**

In the **PAST FIVE YEARS:** (list left or right)

YES NO 28. Do you currently have any incompletely healed injuries? Details \_\_\_\_\_  
 \_\_\_\_\_

YES NO 29. Have you had a fracture during the past five years?  
 Site \_\_\_\_\_ Date \_\_\_\_\_  
 Site \_\_\_\_\_ Date \_\_\_\_\_  
 Site \_\_\_\_\_ Date \_\_\_\_\_

YES NO 30. Do you have a pin, screw or plate somewhere in your body as a result of bone or joint surgery?  
 Date of surgery \_\_\_\_\_ Site \_\_\_\_\_

**A. SHOULDER:**

YES NO 31. Have you had a shoulder or throwing injury during the past five years?  
 Dislocation R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_  
 Subluxation R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_  
 Rotator cuff strain R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_  
 Muscular strain R \_\_\_\_\_ L \_\_\_\_\_ site \_\_\_\_\_ Date(s) \_\_\_\_\_  
 Biceps tendonitis R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_  
 Bursitis R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_  
 Separation R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_  
 Other R \_\_\_\_\_ L \_\_\_\_\_ details \_\_\_\_\_

YES NO 32. Have you ever been advised to have surgery to correct a shoulder condition? Details \_\_\_\_\_  
 \_\_\_\_\_ Date \_\_\_\_\_

YES NO 33. If the answer to 32 is yes, has the surgery been completed? Details \_\_\_\_\_  
 \_\_\_\_\_ Date \_\_\_\_\_

**B. ELBOW-WRIST-HAND:**

YES NO 34. Have you experienced an elbow injury in the past five years?  
 Severe sprain/strain R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_  
 Hyperextension R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_  
 Dislocation R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_  
 Fracture R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_  
 Tennis elbow R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_  
 Other R \_\_\_\_\_ L \_\_\_\_\_ details \_\_\_\_\_

YES NO 35. Have you had surgery on the elbow in the past five years? If yes, give details \_\_\_\_\_  
 \_\_\_\_\_ Date \_\_\_\_\_

YES NO 36. Have you experienced a wrist injury in the past five years?  
 Severe sprain/strain R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_  
 Scaphoid/Colle's fracture R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_  
 Lunate dislocation R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_  
 Ganglion cyst R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_  
 Fractured/Dislocated fingers R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_

YES NO 37. Have you had surgery on the wrist or hand in the past five years? Date(s) \_\_\_\_\_  
 Details \_\_\_\_\_

**C. BACK/HIP:**

YES NO 38. Have you ever had a back injury/hip injury?  
Muscular strain \_\_\_\_\_ Date(s) \_\_\_\_\_  
Lumbar sacral/ Sacroiliac sprain \_\_\_\_\_ Date(s) \_\_\_\_\_  
Sciatic nerve involvement R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_  
Disc injury \_\_\_\_\_ Date(s) \_\_\_\_\_  
Spondylolysis/Spondylolisthesis \_\_\_\_\_ Date(s) \_\_\_\_\_  
Hip injury/hip labral tear \_\_\_\_\_ Date(s) \_\_\_\_\_  
Snapping hip syndrome \_\_\_\_\_ Date(s) \_\_\_\_\_  
Other back/hip \_\_\_\_\_

YES NO 39. If the answer to question 38 is yes, did you seek the advice or care of a medical doctor?

YES NO 40. Have you had any surgery performed on your back?

YES NO 41. Have you ever been told that you have scoliosis?

YES NO 42. If so, is it structural or functional? What was recommended? \_\_\_\_\_

YES NO 43. Have you ever been told that you have lordosis or kyphosis? \_\_\_\_\_

YES NO 44. Do you experience back pain? If yes, from what condition \_\_\_\_\_  
Very seldom \_\_\_\_\_  
Occasionally \_\_\_\_\_  
Frequently \_\_\_\_\_  
Only during or after exercise \_\_\_\_\_

**D. KNEE:**

YES NO 45. Have you ever been told that you injured ligaments in either knee?  
*MCL* R \_\_\_\_\_ L \_\_\_\_\_ *ACL* R \_\_\_\_\_ L \_\_\_\_\_ Date \_\_\_\_\_  
*LCL* R \_\_\_\_\_ L \_\_\_\_\_ *PCL* R \_\_\_\_\_ L \_\_\_\_\_ Date \_\_\_\_\_

YES NO 46. Have you ever been told that you injured cartilage/meniscus in either knee?  
Medial R \_\_\_\_\_ L \_\_\_\_\_ Date \_\_\_\_\_  
Lateral R \_\_\_\_\_ L \_\_\_\_\_ Date \_\_\_\_\_

YES NO 47. Have you ever experienced pain or a grating sensation behind your kneecap? Date \_\_\_\_\_

YES NO 48. Have you ever been advised to have surgery on a knee to correct any knee condition? Date \_\_\_\_\_  
Details \_\_\_\_\_

YES NO 49. If the answer to question 48 is yes, has the surgery been completed? Date \_\_\_\_\_  
Details \_\_\_\_\_

YES NO 50. Have you ever been told that you have Osgood-Schlatter's disease? Date \_\_\_\_\_

YES NO 51. Other knee injuries? Date(s) \_\_\_\_\_ Details \_\_\_\_\_

**E. ANKLE:**

YES NO 52. Have you ever experienced an ankle injury during the past five years that incapacitated you?  
Sprain (outside) R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_  
Sprain (inside) R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_  
Dislocation R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_  
Fracture R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_  
Other R \_\_\_\_\_ L \_\_\_\_\_ Date(s) \_\_\_\_\_

YES NO 53. Have you had surgery on the ankle in the past five years? If yes, give details \_\_\_\_\_  
Date \_\_\_\_\_

**INTERNAL**

- YES NO 54. Are you missing a paired organ (kidney, eye, testicle, etc) Organ \_\_\_\_\_
- YES NO 55. Have you ever been told that you have a hernia? If yes, give details \_\_\_\_\_  
Date \_\_\_\_\_
- YES NO 56. If the answer to question 55 is yes, has the surgery been performed to correct the problem? Date \_\_\_\_\_
- YES NO 57. Have you had any additional operations in the past five years? Date \_\_\_\_\_  
Details \_\_\_\_\_
- YES NO 58. Are you currently on prescribed medication or drugs on a permanent or semi-permanent basis? If so,  
List of meds \_\_\_\_\_  
Why prescribed \_\_\_\_\_
- YES NO 59. Are you taking a NCAA banned substance for ADHD (i.e. Ritalin)? Include a note from treating physician  
with the date of diagnosis stating that non-banned alternatives were considered and that the physician is  
currently monitoring with annual follow-up.
- YES NO 60. Are you allergic to any medication? If yes, give details. Name of medication \_\_\_\_\_  
Reaction \_\_\_\_\_
- YES NO 61. Are you allergic to insect bites? If yes, specify insect \_\_\_\_\_  
Reaction to your last insect bite \_\_\_\_\_
- YES NO 62. Do you have hearing in both ears? If no, give details \_\_\_\_\_  
\_\_\_\_\_
- YES NO 63. For females, do you have a regular menstrual cycle? Why not? \_\_\_\_\_  
\_\_\_\_\_
- YES NO 64. Has your weight fluctuated 20 pounds or more in the past year? If so, give details \_\_\_\_\_  
\_\_\_\_\_
- YES NO 65. **Other relevant information?** Details \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ALL QUESTIONS HAVE BEEN ANSWERED COMPLETELY TO THE BEST OF MY KNOWLEDGE. EACH STUDENT-ATHLETE MUST HAVE INSURANCE COVERAGE AT ALL TIMES TO PARTICPATE. UPDATE THE ATHLETIC TRAINING STAFF WITH ANY INSURANCE CHANGES THROUGHOUT THE YEAR.

**A COPY OF YOUR CURRENT INSURANCE CARD SHOULD ACCOMPANY THIS FORM.**

\_\_\_\_\_  
Signature of Student-Athlete Date

\_\_\_\_\_  
Signature of Parent if Athlete under 18 Date

Mail a signed Release and Waiver, current insurance card, and this questionnaire to:  
Athletics-Clearance  
Utica College  
1600 Burrstone Rd  
Utica, NY 13502