

**University of Missouri at St.Louis Sportsmedicine Department  
Medical History Questionnaire**

Name \_\_\_\_\_

Sport \_\_\_\_\_

Sex M/F

Date of Birth \_\_\_\_\_

**Have you ever been diagnosed with any chronic medical condition?      Yes No**  
**If yes,list condition and date of onset below:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you ever had surgery?      Yes No**  
**If yes,list surgical procedure and date below:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Are you presently taking or have you ever taken any medication?      Yes No**  
**(both prescription and over the counter)**  
**If yes,list below:**

<b>Medication</b>	<b>Dose</b>	<b>How often</b>	<b>Still take?</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Are you taking any supplements(creatine,vitamins,etc.)      Yes No**  
**If yes,list below:**

\_\_\_\_\_  
\_\_\_\_\_

**Do you have any drug allergies or environmental/food allergies?      Yes No**  
**If yes,list below:**

\_\_\_\_\_  
\_\_\_\_\_

**Do you or have you ever smoked?      Yes No**

<b>Does any disease run in your family? If yes,list below:</b>	<b>Yes No</b>
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<b>Has a family member died before the age of 50? If yes,list below:</b>	<b>Yes No</b>
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<b>Have you ever become dizzy during/after exercise?</b>	<b>Yes No</b>
<b>Have you ever fainted?</b>	<b>Yes No</b>
<b>Have you ever had chest pain during/after exercise?</b>	<b>Yes No</b>
<b>Have you ever had racing of your heart or skipped heartbeats?</b>	<b>Yes No</b>
<b>Have you ever been diagnosed with a heart murmur?</b>	<b>Yes No</b>
<b>Have you ever had a severe viral infection such as mononucleosis or myocarditis?</b>	<b>Yes No</b>
<b>Have you had sudden severe episodes or recurrent episodes of coughing,wheezing,chest tightness or shortness of breath?</b>	<b>Yes No</b>
<b>Do you have coughing,wheezing or shortness of breath...</b>	
<b>...at night that has awakened you?</b>	<b>Yes No</b>
<b>...upon awakening?</b>	<b>Yes No</b>
<b>...after running,moderate exercise or physical activity?</b>	<b>Yes No</b>
<b>Have you used any medications that help you breathe better? If yes,list below:</b>	<b>Yes No</b>
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<b>Have you ever been diagnosed with ADD or ADHD? If yes,are you presently on medication?List below:</b>	<b>Yes No</b>
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<b>Do you or have you ever had anemia?</b>	<b>Yes No</b>
<b>Do you have sicle cell anemia or sickle cell trait?</b>	<b>Yes No</b>
<b>Are you diabetic?</b>	<b>Yes No</b>
<b>Do you or have you ever had frequent heartburn,acid reflux,gastritis, ulcer(s) or other stomach problems?</b>	<b>Yes No</b>
<b>Do you have frequent diarrhea or constipation?</b>	<b>Yes No</b>

Are you missing or have function of only one paired organ?  
(eye,ear,lung,kidney,testicle,ovary) Yes No

Have you ever been knocked unconscious?  
If yes,describe below: Yes No

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Have you ever been diagnosed with a concussion?  
If yes,list date below: Yes No

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Do you have frequent headaches? Yes No

Have you ever had a seizure? Yes No

Have you ever been NOT cleared medically to participate in a sport  
or had restrictions placed on participation in a sport? Yes No

Have you ever fractured a bone?  
If yes,list below: Yes No

Bone	Date
_____	_____
_____	_____
_____	_____

Did you have to have surgery? Yes No

Have you ever dislocated a joint?  
If yes,list below: Yes No

Joint	Date
_____	_____
_____	_____
_____	_____

Did you have to have surgery? Yes No

*For Females Only*

Do you have a period every month? Yes No

Have you ever had an abnormal or irregular menses? Yes No

Do you use...

...birth control pills Yes No

...birth control patch Yes No

...IUD Yes No

Are you presently receiving the HPV(Gardasil)vaccination? Yes No

**I hereby state that, to the best of my knowledge, all of the answers listed in this questionnaire are correct and accurate.**

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**Student-Athlete's Signature      Date**

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**Parent's Signature (if student-athlete is a minor)      Date**