I. This questionnaire is part of your physical examination for participation in college athletics. This is part of your medical record and will be treated confidentially.

II. Please fill in all blanks to the best of your knowledge. This will be screened by our team physician.

III. Answer all questions.

What sport? ____________________________ Year at GWU 1st 2nd 3rd 4th 5th

Name_________________________________________________________ Date____________________

Social Security Number_________________________ Age_____________ Birth Date___________

GWU Campus Box_________________________ Cell Number__________________________

Home Address__________________________________________________________

City_________________________ State______________ Zip__________________________

Parent or Guardian_________________________ Phone__________________________

Parent or Guardian’s Address__________________________________________

In Case of Injury, Notify_________________________ Phone__________________________

Family Doctor_________________________ Address__________________________

City_________________________ State______________ Zip__________________________

Family History

<table>
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<tr>
<th>Age</th>
<th>Father</th>
<th>If Living</th>
<th>Cause of Death</th>
<th>Age at Death</th>
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Who in Your Family Has Had: Goiter_________ Diabetes_________

Cancer_________ Tuberculosis_________ Allergies_________

Asthma_________ Heart Attacks Before at 60________________

High Blood Pressure_________ Gout_________ Strokes Before Age 60_________

Mental Disorder_________ Convulsion/Epilepsy_________

Migraine Headache_________

MARITAL HISTORY:

Married_________ Single_________ Children_________

Spouse’s Name________________________________ Phone_________________________

Spouse’s Address__________________________________________________________
HEALTH HISTORY
Please check the correct answer following each question:

A. HEAD
1. Did you ever have spasms or convulsions as an infant?  Yes__ No__

2. Have you ever had a seizure, convulsion fit or epileptic attack?  Yes__ No__

3. Have you ever been diagnosed with a concussion (with /without loss of consciousness)?  
   1. How many times have you been diagnosed with a concussion?_____________________
   2. When was your last concussion?__________________
   3. Did this occur while participating in athletics?  Yes__ No__
      If yes, which sports:________________________________
   4. Were you seen by a physician?  Yes__ No__
   5. How long after suffering a concussion were you allowed to participate in athletics again?
      Please Describe:____________________________________
   6. When were you allowed to return to participation with no restrictions?________

4. Have you had loss of consciousness/been knocked out?  Yes__ No__
   1. If yes, how many times____________
   2. How long were you unconscious?
      Less than 5 minute ______ Less than 15 minutes______ Over 15 minutes______

5. Have you passed out, fainted, or blacked out?  Yes__ No__

6. Have you been hospitalized for a head injury?  Yes__ No__

7. Have you ever had, or has it been suggested that you should have, a brain wave test
   (EEG or Electroencephalogram)?  Yes__ No__

8. Have you ever had, or has it been suggested that you have, a skull X-Ray
   or brain scan, CT Scan, or MRI done?  Yes__ No__

9. Have you ever had an injury with concussion like symptoms that you did not report?  Yes__ No__
   If yes please describe:________________________________________________________________

10. Have you ever had a skull fracture?  Yes__ No__

11. Have you ever had amnesia (loss of memory) following a head injury?  Yes__ No__

12. Do you now, or have you ever, suffered from frequent headaches?  Yes__ No__

13. Have you ever had blurred or double vision?  Yes__ No__

14. Have you ever been baseline tested?  Yes__ No__
   If yes, please circle any test you have taken:
   Baseline Symptoms Sheet    SCAT    ImPACT    Other:_____________________

15. Has it ever been recommended that you do not participate in athletic related activity?  Yes__ No__

B. EYES
1. Have you ever been told you had a lazy eye?  Yes__ No__

2. Do you have an absence of one eye?  Yes__ No__

3. Do you have diminished or abnormal vision?  Yes__ No__

4. Do you normally wear glasses?  Yes__ No__

5. Do you wear contact lenses?
   If yes, hard or soft? __________ Contacts fitted by: ______________________
6. Last seen by doctor for vision check? ________________________________

7. Have you ever had an eye injury?  Yes__ No__
8. Have you ever had eye surgery?  Yes__ No__

C. EARS
1. Do you have any defect of hearing?  Yes__ No__
2. Do you have any drainage?  Yes__ No__
3. Do you have any ringing in your ears?  Yes__ No__
4. Have you ever had an ear injury or ear surgery?  Yes__ No__

D. NOSE
1. Do you have frequent nose bleeds?  Yes__ No__
2. Have you ever broken your nose?  Yes__ No__
3. If broken, did you have surgery?  Yes__ No__
4. Have you had difficulty breathing through your nose?  Yes__ No__

E. DENTAL AND THROAT
1. Do you have any false teeth or plates?  Yes__ No__
2. Have you fractured a tooth?  Yes__ No__
3. Have you had a tooth knocked out?  Yes__ No__
4. Have you had more than one tooth knocked out?  Yes__ No__
5. Did you miss practice because of the injury?  Yes__ No__
6. Dentist last seen: Name________________________ Month______ Year__________
7. Wisdom teeth?  In__ Out__

F. MUSCULOSKELETAL
a. Dislocations
1. Have you ever dislocated a joint?  Yes__ No__
2. Please check involved area or areas:
   Shoulder (L)_____ (R)_____  Finger (L)_____ (R)_____  Knee (L)_____ (R)_____  A-C Separation (L)_____ (R)_____  Hip (L)_____ (R)_____  Ankle (L)_____ (R)_____  Elbow (L)_____ (R)_____  Patella (L)_____ (R)_____  Other_______________________
3. Has the dislocation occurred more than once?  Yes__ No__
   How many times__________ Last occurrence________________
4. Did you see a physician with initial dislocation?  Yes__ No__
5. Were X-Rays made?  Yes__ No__
6. Was the involved area immobilized (put in cast splint or other immobilization?)  Yes__ No__
7. Did you have surgery?  Yes__ No__
8. Were you given specific exercises following the injury or surgery?  Yes__ No__
b. Fractures
1. Have you ever had a broken bone? Yes___ No___
2. Please check the involved areas:
   Skull______  Rib(s) (R or L)__________  Hand (R or L) ________  Lower Leg (R or L)_______
   Face_______  Clavicle (R or L)_______  Wrist (R or L) ________  Ankle (R or L) __________
   Nose_______  Arm (R or L)___________  Pelvis/Hip ____________  Foot (R or L) __________
   Neck_______  Forearm (R or L) _______  Femur (R or L) ________  Other____________________
3. Was the fracture a result of organized participation in athletics? Yes___ No___
   What sport?________________________________________
4. Was your athletic performance altered following injury? Yes___ No___
5. Do you have any residual defect as a result of the fracture? Yes___ No___

c. Muscle
1. Have you ever had a bad “muscle pull” or strain? Yes___ No___
   What muscle?_______________________________________
2. How much time did you miss from practice?
   Less than 2 days _____  Less than 1 week _____  More than 1 week _____
3. Did the injury re-occur? Yes___ No___
4. Did the muscle strain occur initially:
   Before high school _____  During high school _____  During college _____

d. Myositis Ossificans Traumatic
1. Have you ever had calcium form in a muscle following a bad bruise? Yes___ No___
   Right__________  Left________________
2. How much time did you miss from practice?_____________________________________
3. Was the calcium surgically removed? Yes___ No___
4. Do you still have trouble as the result of this injury? Yes___ No___

e. Neck
1. Have you ever had a neck injury? Yes___ No___
2. Have you ever had a fractured neck or spine? Yes___ No___
3. Have you ever sustained a neck injury while playing organized sports? Yes___ No___
4. Did you have numbness, burning, or sharp pain in your arms or hands? Yes___ No___
5. Did you see a physician? Yes___ No___
6. Were X-Rays made? Yes___ No___
7. Were you in a hospital or infirmary? Yes___ No___
8. How long did you miss practice following injury?
   Less than 2 days _____  Less than 1 week _____  More than 1 week _____
9. Have you ever had a pinched nerve? Yes___ No___
10. Have you ever worn a “horse collar” because of neck injury? Yes___ No___
11. Did the collar reduce the incidence of neck injury? Yes___ No___
12. Have you ever been taught to “spear” with your head when you tackle and block? Yes___ No___
f. Spine
1. Have you ever injured your back?
   Yes___ No___
2. Have you injured your back more than once?
   Yes___ No___
3. When did you first have back trouble?
   Before high school______ During high school______ During college______
4. Did you see a physician?
   Yes___ No___
5. Were X-Rays made?
   Yes___ No___
6. Did you have back surgery? Date____________
   Name of surgeon & orthopedic office ________________________________
   What was repaired? _____________________________________________
7. How long did you miss practice?
   Less than 2 days______ Less than 1 week______ More than 1 week______
8. Were you ever told that you have a spinal defect that has been present since birth?
   Yes___ No___
9. Were you given specific back exercises following surgery or injury?
   Yes___ No___
10. Do you have frequent back pain?
    Yes___ No___
g. Shoulder
1. Does your shoulder ever give away?
   Yes___ No___
   Does your shoulder feel unstable?
   Yes___ No___
   Does your shoulder hurt following activity?
   Yes___ No___
2. Have you had a significant shoulder injury? (L)______ (R)______
3. When did you first injure your shoulder?
   Before high school______ During high school______ During college______
4. Did you see a physician?
   Yes___ No___
5. Did you have X-rays or an MRI done?
   Yes___ No___
6. Did you have shoulder surgery? Date____________
   Name of surgeon & orthopedic office ________________________________
   What was repaired? _____________________________________________
7. Were you given specific shoulder exercises following surgery or injury?
   Yes___ No___
8. How long did you miss practice?
   Less than two days______ Less than one week______ More than one week______
9. Have you had significant injuries to both shoulders?
   Yes___ No___
10. Have you had surgery on either shoulder more than once?
    Yes___ No___
11. If you’ve previously injured your shoulder, was it properly treated?
    Yes___ No___
h. Elbow
2. Have you had a significant elbow injury? (L)______ (R)______
3. When did you first injure your elbow?
   Before high school______ During high school______ During college______
4. Did you see a physician?  Yes__ No__
5. Did you have X-rays or an MRI done?  Yes__ No__
6. Did you have elbow surgery? Date ______________
   Name of surgeon & orthopedic office __________________________
   What was repaired? __________________________
7. Were you given specific elbow exercises following surgery or injury?  Yes__ No__
8. How long did you miss practice?
   Less than two days ___ Less than one week ___ More than one week ___
9. Have you had significant injuries to both elbows?  Yes__ No__
10. Have you had surgery on either elbows more than once?  Yes__ No__
11. If you’ve previously injured your elbow, was it properly treated?  Yes__ No__

i. Wrist/Hand/Finger
1. Have you ever had a wrist/hand/finger problem or injury?  (R) ___ (L) ___
   What type of problem? __________________________
2. Did you see a physician?  Yes__ No__
3. Did you have X-rays or an MRI done?  Yes__ No__
4. Have you had wrist/hand/finger surgery?  Yes__ No__
5. If you’ve previously injured your wrist, hand or finger, was it properly treated?  Yes__ No__

j. Hip
1. Does your hip ever give away?  Yes__ No__
   Does your hip feel unstable?  Yes__ No__
   Does your hip hurt following activity?  Yes__ No__
2. Have you had a significant hip injury?  (L) ___ (R) ___
3. When did you first injure your hip?
   Before high school _____ During high school _____ During college _____
4. Did you see a physician?  Yes__ No__
5. Did you have X-rays or an MRI done?  Yes__ No__
6. Did you have hip surgery? Date ______________
   Name of surgeon & orthopedic office __________________________
   What was repaired? __________________________
7. Were you given specific hip exercises following surgery or injury?  Yes__ No__
8. How long did you miss practice?
   Less than two days ___ Less than one week ___ More than one week ___
9. Have you had significant injuries to both hips?  Yes__ No__
10. Have you had surgery on either hip more than once?  Yes__ No__
11. If you’ve previously injured your hip, was it properly treated?  Yes__ No__
k. Knee
1. Do you have occasional swelling of the knee? Yes__ No__
   Does your knee ever lock up? Yes__ No__
   Does your knee ever give away? Yes__ No__
   Does your knee feel unstable? Yes__ No__
   Does your knee hurt following activity? Yes__ No__
2. Have you had a significant knee injury?  (L)_____ (R)_____ Yes__ No__
3. When did you first injure your knee? Before high school_____ During high school_____ During college_____
4. Did you see a physician? Yes__ No__
5. Did you have an MRI or X-rays completed? Yes__ No__
6. Did you have knee surgery? Date_________
   Name of surgeon & orthopedic office ___________________________
   What was repaired? ___________________________
7. Were you given specific knee exercises following surgery or injury? Yes__ No__
8. How long did you miss practice? Less than two days_____ Less than one week_____ More than one week_____
9. Have you had significant injuries to both knees? Yes__ No__
10. Have you had surgery on either knee more than once? Yes__ No__
11. If you’ve previously injured your knee, was it properly treated? Yes__ No__

1. Ankle
1. Does your ankle ever give away? Yes__ No__
   Does your ankle feel unstable? Yes__ No__
   Does your ankle hurt following activity? Yes__ No__
2. Have you ever injured your ankle?  (R)_____ (L)_____ Yes__ No__
3. When did you first injure your ankle? Before high school_____ During high school_____ During college_____
4. Did you see a physician? Yes__ No__
5. Did you have X-rays or an MRI done? Yes__ No__
6. Did you have ankle surgery? Date_________
   Name of surgeon & orthopedic office ___________________________
   What was repaired? ___________________________
7. Were you given specific ankle exercises following surgery or injury? Yes__ No__
8. How long did you miss practice? Less than two days_____ Less than one week_____ More than one week_____
9. When first injured, was your ankle taped? Yes__ No__
10. Did you have any immobilization? Yes__ No__
11. Have you had recurrent sprains of the ankle? Yes__ No__
12. At present, do you always tape or wrap your ankles? Yes__ No__
13. Have you had significant injuries to both ankles? Yes__ No__
14. Have you had surgery on either ankles more than once? Yes__ No__
15. If you’ve previously injured your ankle, was it properly treated? Yes__ No__

m. Foot or Toe
1. Have you ever had a foot problem? (R)____ (L)____ Yes__ No__
2. What type of problem? ________________________________ Yes__ No__
3. Did you see a physician? Yes__ No__
   Was surgery required? Yes__ No__
4. Do you wear arch supports or orthotics? Yes__ No__
   What type: ________________________________________ Yes__ No__
5. Have you ever had a toe problem or injury? Yes__ No__
   Please describe: ____________________________________ Yes__ No__

G. CARDIAC
Do you have or have you ever had?
1. High blood pressure Yes__ No__ 5. Palpitation or flutter of heart Yes__ No__
2. Any disease of the valves of the heart Yes__ No__ 6. Heart Murmur Yes__ No__
3. Any congenital heart disease present since birth Yes__ No__ 7. Shortness of breath at rest Yes__ No__
4. Abnormal heart rate Yes__ No__ 8. Frequent cough Yes__ No__

H. GENITOURINARY
1. Absence of one kidney Yes__ No__ 4. Blood in urine Yes__ No__
2. Frequent urinary infection Yes__ No__ 5. Sexually Transmitted Disease Yes__ No__
3. Kidney stone Yes__ No__

For Males Only:
A. Do you have absence of either testicle? Yes__ No__
   B. Is one testicle much smaller than the other? Yes__ No__

For Females Only:
A. Have you ever had an injury to your breasts? Yes__ No__
   F. How long do your periods typically last? ________ days
   G. How often do you have a period? Every______ days
B. Have you ever had surgery on your breasts? Yes__ No__
   H. Are your periods painful? Yes__ No__
C. Have you ever had surgery on your ovaries or uterus? Yes__ No__
   I. Do you notice any clotting? Yes__ No__
   J. Do you use any contraceptives? Yes__ No__
D. Do you have both of your ovaries? Yes__ No__
   K. Do you have any recurrent gynecological infections? Yes__ No__
   E. When was your last menstrual period? ____________

I. GASTROINTESTINAL
1. Frequent diarrhea Yes__ No__ 6. Liver infection (hepatitis) Yes__ No__
2. Frequent nausea Yes__ No__ 7. Jaundice Yes__ No__
### Medical History

**J. SKIN**
1. Frequent boils
2. Severe acne
3. Athletes' foot

**K. MISCELLANEOUS DISEASE**
1. Diabetes
2. Cancer
3. Polio
4. Measles
5. Frequent strep throat
6. Seasonal allergy
7. Abnormal bruising
8. Hepatitis
9. Asthma
10. Infectious mononucleosis
11. Scarlet fever
12. Tuberculosis
13. Epilepsy
14. Abnormal bleeding tendency
15. Frequent sinus infection
16. Sickle Cell
17. Food allergy
18. Drug allergy

**L. SURGERY**
1. Appendectomy
2. Tonsillectomy
3. Hernia repair

**M. HEAT DISORDER**
1. Have you ever had trouble with dehydration (excess loss of salt or water)?
2. Have you ever had heat exhaustion?
3. Have you ever had a heat stroke?
4. Were you hospitalized?
5. How long did you miss practice?
   - Less than 2 days
   - Less than 1 week
   - More than 1 week

**N. IMMUNIZATIONS**
1. Have you been immunized against tetanus?
2. Have you been immunized against the flu?
3. Have you been immunized against Hepatitis B?

**O. DRUG, FOOD SUPPLEMENTS, AND MISCELLANEOUS AGENTS**
Check the appropriate space according to your use of the following items

1. Vitamin
2. Stimulants (Benzedrine, amphetamine)
3. Cigarettes
4. Smokeless tobacco
5. Sleeping pills
6. Alcoholic Beverages
7. Anabolic agents (Growth stimulants or hormones)
8. Weight loss products
9. Nutritional supplements
10. ADD/ADHD
**P. MENTAL FITNESS**

1. Have you ever been treated for:

   A) Psychiatric/psychological condition  Yes ___ No ___

   B) depression or attempted suicide  Yes ___ No ___

   C) anorexia or bulimia  Yes ___ No ___

   D) drug/alcohol addiction  Yes ___ No ___

2. Are you currently on medications for any mental illness?  Yes ___ No ___

   If yes, please list medications: ____________________________________________________

3. Do you see any possibility of any need for counseling in the future?  Yes ___ No ___

**Q. Miscellaneous**

1. Do you currently have any medical condition which would affect your participation in athletics at Gardner-Webb University?  Yes ___ No ___

   If yes, please explain: ______________________________________________________________

   ______________________________________________________________

   ______________________________________________________________

   ______________________________________________________________

To the best of my knowledge the answers to the questions in this questionnaire are true.

Signature ___________________________________________ Date ___________