

GRINNELL COLLEGE



Medical History Questionnaire for 2000-10 Academic Year

Name: _____

Date: _____

Sport(s): _____

School PO Box: _____

Birth Date: _____

School Phone #: _____

Student Cell Phone #: _____

Class Year (please circle) **1 2 3 4**

Please explain "Yes" answers

1. Have you ever been hospitalized? _____ Yes No
2. Have you ever had surgery? _____ Yes No
3. Are you presently taking medication? _____ Yes No
4. Do you have any allergies (medicine, food, etc.) _____ Yes No

5. Have you ever passed out during exercise _____ Yes No
Have you ever had chest pain _____ Yes No
Do you tire quicker than your friends during exercise? _____ Yes No
Have you ever been told you have a heart murmur? _____ Yes No
Have you ever had high blood pressure? _____ Yes No
Have you ever had racing of your heart or skipped beats? _____ Yes No
Has anyone in your family died of heart problems or sudden death? _____ Yes No
Have you been told you have sickle-cell anemia? _____ Yes No

6. Do you have any skin problems (itching, moles, etc.)? _____ Yes No
7. Have you ever had a head injury? _____ Yes No
Have you ever been "knocked out"? _____ Yes No
Have you ever had a seizure? _____ Yes No
Have you had a "stinger" or "burner"? _____ Yes No

8. Have you ever injured (sprained, dislocated, fractured, etc.) one of the following (indicate R or L):

_____ hand _____ wrist _____ forearm _____ elbow _____ arm _____ shoulder
_____ neck _____ chest _____ back _____ hip _____ thigh _____ knee
_____ shin _____ calf _____ ankle _____ foot

Please indicate type of injury, date of injury, and any limitations or continuing problems:

9. Have you ever had heat cramps? _____ Yes No
10. Have you ever been dizzy or passed out in the heat? _____ Yes No
11. Have you been advised by a physician or by your parents not to participate in athletic events? _____ Yes No



12. Have you been treated for a disease or illness during the past 12 months? _____ Yes No

13. Are you currently under the care of a physician? _____ Yes No
14. Have you been found to have only one of a usually paired organ (ex. kidney, eye)? _____ Yes No

15. Do you wear glasses or contacts? _____ Yes No
16. Do you use special pads or braces? _____ Yes No
17. What was the date of your last tetanus shot? _____
18. Have you ever been diagnosed as having: mononucleosis _____ hepatitis _____ asthma _____
tuberculosis _____ diabetes _____ headaches (frequent) _____ eye injury _____ stomach ulcer _____
19. Have you ever been treated for anemia? _____ Yes No
20. How many meals do you eat each day? _____ How many snacks? _____
21. Are there certain food groups you refuse to eat (ex. bread, meat)? _____ Yes No
22. Have you ever been on a diet? _____ Yes No
23. What is your present weight? _____ Are you happy with this weight? _____ Yes No
If not, what would you liked to weigh? _____
24. Have you ever been worried that you might have an eating disorder like bulimia or anorexia _____ Yes No
25. Has anyone ever expressed concern that you may have an eating disorder? _____ Yes No
26. Have you ever tried to control your weight by (please check all that apply):
Vomiting _____ diet pills _____ diuretics _____ using laxatives _____ ?
27. Have you ever been treated for an eating disorder? _____ Yes No

For Women Only

28. How old were you when you had your first menstrual period? _____
29. How often do you have your period? _____
30. How many periods have you had in the last 12 months? _____
31. How long do your periods last? _____
32. Do you ever have trouble with heavy bleeding? _____ Yes No
33. Do you ever experience cramps during your period? _____ Yes No
If so, how do you treat them? _____

With my signature, I, the undersigned, understand that there is an Eating Disorder Protocol which is available at the Athletic Department Office. I also understand that there are risks associated with athletic activities, especially contact/collision sports: Including, but not limited to, head and neck injuries.

Signature of Athlete

Date

