Northern Illinois University 2008-2009	Name:
Intercollegiate Athletics/Health Services	NIU ID #
NCAA Student Health History -- Initial Form	Sport Year in School Fall 2008 1 2 3 4 5 Transfer

HAVE YOU EVERHAD ANY OF THE FOLLOWING?			SPORTS MEDICINE STAFF USE ONLY
Y	N	Asthma	Type: (circle one) Ongoing Illness related Exercise induced Allergy related
			Diagnosed by: How long have you had it?
			Usual peak flow (if measured) :
			Have you been hospitalized for asthma or ER? Y / N When?
			Have you taken oral steroids (prednisone)? Y / N
			Family history of Asthma? Y / N Who?
			How controled are symptoms? (circle) Good Bad Depends
			Trouble sleeping or wake up with shortness of breath? Y / N
			Do you use an inhaler? Y / N Type: Use inhaler if not exercising? Y / N
			Ever had pulmonary function testing (spirometry)? Y / N
			Do you have frequent respiratory infections (bronchitis, pneumonia)? Y / N
Y	N	Seasonal allergies that require medical attention?	Have you ever had skin testing for allergies? Y / N
			Do you need an inhaler or nasal steroid spray for your allergies? Y / N
			Ever needed steroid shot or oral (prednisone) for allergies? Y / N
			During exercise/exertion, do allergies cause: (circle) Wheezing Coughing Shortness of Breath
Y	N	Head injury, concussion, been knocked out, or lost your memory for any period of time? (Circle appropriate choice)	Describe incidence(s), including age:
			ER or hospitalized? Y / N Unconscious? Y / N CT scan or MRI of brain? Y / N
			Still having problems related to this? Y / N
Y	N	Heat exhaustion, heat stroke, or been restricted from participation due to heat illness? (Circle appropriate choice)	Describe incidence(s):
			How many times has it happened? How long ago?
			What symptoms: (circle) nausea/vomiting headache dizziness cramps passed out
			What did coach or athletic trainer do to help?
			ER or hospitalized? Y / N Family history of thyroid problem? Y / N
			How do you hydrate for practice or competition?

Incoming Athlete

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HAVE YOU EVER HAD ANY OF THE FOLLOWING?	**SPORTS MEDICINE STAFF USE ONLY**

Y	N	Question	
Y	N	During or after exercise, (other than heat or asthma related) do you cough, wheeze or have trouble breathing, get chest pain, get tired more quickly than your friends, have unusual racing of your heart or skipped heartbeats, or ever pass out? (Circle appropriate choice(s))	Describe when you get this:
			How long does it last?
			What makes it go away?
			Describe chest pain: (circle) Dull Sharp Crushing Pressure N/A
			Pain occurs in: (circle) Neck Jaw Arm N/A
			Dizziness is: (circle) Lightheaded Spinning N/A
			Does dizziness cause you to stop exercising? Y / N
			Irregular heartbeat is: (circle) Pounding Racing Skipping N/A
			Does shortness of breath cause coughing or wheezing? Y / N
			Do you have trouble with non-athletic activities (walking, climbing stairs)? Y / N
			Have you been diagnosed or treated by a physician for this? Y / N
			Do you or have you taken: (circle) Energy drinks Diet pills N/A What kind?
Y	N	Heart condition or heart murmur, high blood pressure or high cholesterol? (Circle appropriate choice -- if you circle Heart condition, please indicate type in this box)	When was it diagnosed? By whom?
			Do you still have it? Y / N
			Current symptoms: (circle) headaches chest pain racing heart feeling flushed dizziness shortness of breath passing out or tiredness frequent muslce cramps N/A Other (explain):
			If you have high blood pressure or cholesterol, did you have a change in diet? Y / N N/A
			Did you see: (circle) Nutritionist Cardiologist N/A
			Have you ever been restriced or denied participation in sports due to this heart problem? Y / N
			Do you have mitral valve prolapse? Y / N
			Do you need to take antibiotics before dentist or surgery? Y / N
			Was murmur diagnosed as baby?
			Family history? Y / N Who? Which condition?
Y	N	Do you or a member of your family have a history of Marfan's syndrome?	Appearance suggestive of Marfan's: (circle) Height: Men >6' (72") Women > 5' 10" (70") Greater arm span than height
			Height of parents Height of siblings

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PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.	**SPORTS MEDICINE STAFF USE ONLY**

Y	N	Question	Sports Medicine Staff Use Only
Y	N	In the past 12 months did you have any injury or illness that required medical attention?	Describe illness or injury: Are you undergoing any rehabilitation (PT)? Y / N Were you treated by an Orthopedist? Y / N Are you still under a doctors care? Y / N Are you fully recovered? Y / N
Y	N	Currently taking medicationsfor any reason (excluding oral contraceptives)?	Describe type and purpose of medication:
Y	N	Are you currently taking any supplements or vitamins?	Describe type and purpose:
Y	N	Have you had a severe viral infection within the last month?	Indicate which: (circle) Mono Pneumonia Flu Myocarditis
Y	N	Have you ever been diagnosed with diabetes or hyoglycemia?	Explain:
Y	N	Has any family member or close relative died of heart problems or sudden unexpected death before age 50?	Describe incidence(s):
Y	N	Do you want to weigh more than you do now?	Goal Weight: lbs.
Y	N	Do you want to weigh less than you do now?	Goal Weight: lbs.
Y	N	Do you, or have you, had an eating disorder?	Explain:
Y	N	Do you want to speak to a dietitian or athletic trainer regarding weight issues?	
Y	N	Do you lose weight regularly to meet weight requirements for your sport?	
Y	N	Do you feel more stressed out or depressed than you think you should?	Explain which and why:
Y	N	Are you missing an eye, kidney, or ovary?	Explain:
Y	N	Allergies to: (circle) Drugs, Food, Bee Stings	Explain:
Y	N	Have you ever had: (circle one) 2-D Echo or Echo Cardiogram / EKG	When? For what purpose?
Y	N	Do you have any medical conditions not listed above?	Explain:

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PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.	**IF YES, PLEASE EXPLAIN BY ANSWERING THE FOLLOWING QUESTIONS.**

FEMALES ONLY

		When was your very first menstrual period?	First day of most recent menstrual period?
Y	N	Menstrual irregularity?	Loss of periods? Y / N Number of periods in the last year:
Y	N	Taking oral contraceptives?	What kind?
Y	N	Stress fractures	When? Where?
Y	N	Do you consume 1200mg of calcium daily? (One cup skim milk, yogurt, or orange juice = 300mg)	
Y	N	Significant weight changes or weight concerns?	Explain:

MALES ONLY

Y	N	Have you ever had a hernia?	When?
Y	N	Are you missing a testicle or do you have any testicular dysfunction?	Explain:

MARFAN SCREENING: TO BE COMPLETED IF ANSWERED YES TO HISTORY OF MARFANS QUESTIONS ABOVE

Measurements Done By Certified Athletic Trainer

Height (inches):

Arm span in inches (palms down-tip to tip of longest fingers):

Upper segment to lower segment ratio: Crown to pubis: in. Pubis to heels: in.

Thumb Sign: Y / N Wrist Sign: Y / N

Vision - myopic Y / N Scoliosis: Y / N

Anterior Chest Deformity: Y / N Striae: Y / N

MVP or CV abnormality: Y / N

Referral for: (circle) Slit Lamp Echo Geneticist

Additional Notes:

Athlete Signature Date: / /

Physician Signature: Date: / /

Reviewed By Date: / /

NCAA HEALTH HISTORY FORM 1/30/08 PAS

Incoming Athlete