

Name:	
NIU ID #	
Sport	Year in School Fall 2008 1 2 3 4 5 Transfer

IN THE PAST 12 MONTHS HAVE YOU HAD 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 controlled 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, nasal steroid spray, steroid shot or oral (prednisone) for your allergies? Y / N (circle appropriate choice) During exercise/exertion, do allergies cause: (circle) Wheezing Coughing Shortness of Breath N/A
Y	N	During or after exercise, (other than heat or asthma related) have you had cough, wheeze or have trouble breathing, passed out, chest pain, get tired more quickly than your friends, unusual racing of your heart or skipped heartbeats? (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 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 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 restricted 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? Y / N Family history? Y / N Who? _____ Which condition? _____
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

Returning Athlete

