THIS INFORMATION MUST BE SENT TO THE OFFICE OF THE HEAD ATHLETIC TRAINER **TWO WEEKS PRIOR** TO YOUR PHYSICAL. IF YOU HAVE ANY QUESTIONS PLEASE CALL **201-200-3163**.

SEND TO: JESSICA SPRINGSTEAD, MEd, ATC, ATL
HEAD ATHLETIC TRAINER
C/O NJCU ATHLETICS, JMAC
2039 KENNEDY BLVD, JERSEY CITY, NJ 07305

NEW JERSEY CITY UNIVERSITY ATHLETICS
MEDICAL HISTORY

Please fill out this form in its entirety. Be sure to sign the back page. Failure to disclose all medical conditions could disqualify you from being covered under the university athletic insurance policy.

THIS FORM MUST BE RETURNED WITH THE INFORMATION SHEET TWO WEEKS PRIOR TO YOUR PHYSICAL.

Name:____

Social Security Number:____________________________

Sport:____

Family Physician:
____

Address:
____

Phone: (___)_______________________________________

FAMILY HISTORY

Y for Yes
N for No
U for Unknown

	Father	Mother	Brothers 1	2	3	4	5	Sisters 1	2	3	4	5	Comments
Age													
Health G)good (B)bad													
Cancer													
Tuberculosis													
Diabetes													
Heart Troubles													
High Blood Pressure													
Stroke													
Gastrointestinal													
Hepatitis													
Asthma, Hayfever													
Blood Disease													
Age (at death)													
Cause of Death													

General Medical History

Immunizations

1. Tetanus shot Yes______ No______ Date_______
2. MMR shot Yes______ No______ Date_______
3. Hepatitis B shot Yes______ No______ Date_______

NOTE: MMR is required by state mandate, proof of MMR must be forwarded to health services or registration will be canceled. Please include copy of immunization records with this packet when you return it.

Medications

Are you currently taking ANY medications (including aspirin, vitamins, birth control pills, herbal supplements, creatine, etc.)?

List ALL medications taken in the PAST 6 WEEKS:

____
____
____
____

Allergies

Are you allergic to any foods, medicines, bees or anything else?

List allergies:____
____
____
____

Do you have a history of:

1. YES NO Diabetes
2. YES NO Convulsions or epilepsy
3. YES NO Mononucleosis
4. YES NO Asthma
5. YES NO High or low blood pressure
6. YES NO Anemia (low blood count)
7. YES NO Cancer
8. YES NO Gastrointestinal Problems
9. YES NO Kidney Disease
10. YES NO Absence of any organ
11. YES NO Hernia
12. YES NO Menstrual Disorder
13. YES NO High cholesterol
14. YES NO Tuberculosis
15. YES NO Hepatitis
16. YES NO Heart Murmurs
17. YES NO Other heart problems

Please comment on all YES responses including dates and treatments/medications

____
____
____
____
____

Do you get:

Chest Pains	YES________	NO__________
Frequent Headaches	YES________	NO__________
Nose bleeds	YES________	NO__________
Dizziness	YES________	NO__________
Palpitations or chest pounding	YES________	NO__________
Shortness of breath	YES________	NO__________
Blurring of vision	YES________	NO__________

Have you ever had surgery? Please provide dates and body parts.

____
____
____
____

Are you currently being treated for any medical condition? Please explain. Please include physicians name and #.

____
____

____

Are you presently being treated by a chiropractor. YES _____ NO ______
If Yes please explain. (For what medical condition, how often)

____
____
____

INJURY HISTORY

I.Head Injury

Concussion

a. Have you ever had a concussion? Yes____ No____
b. How many? ______
c. Have you ever had amnesia? Yes____ No_____ How long___________
d. Have you ever had an MRI or CAT scan associated with a concussion? ____________Date_________ Where______________
c. Did you miss playing time, how much? _____________

Unconsciousness

a. Have you ever been knocked unconscious? Yes____ No____
b. How long were you unconscious? Less than 1 minute____
   Less than 5 minutes____
   More than 5 Minutes____
c. Were you evaluated by a physician? Yes___No___
   Name______________________
d. Were you admitted to a hospital? Yes___No___
   Name______________________
e. How long after the injury were you permitted to resume play?
   Less than 2 days _____
   Less than 1 week _____
   Over 1 week _____

Nose

a. Do you get nose bleeds? Yes____ No____
b. Have you ever broken your nose? Yes____ No____
c. Have you had nasal surgery, when? Yes____ No____ Date ______
   MD name____

Eyes

a. Do you have any vision impairments that could impede participation? Yes____ No____ Explain_______________________
   ____

Ears

a. Have you had cauliflower ear? Yes____ No____
b. Do you have any hearing impairments that could impede participation? Yes____ No____ Explain_______________________
   ____

II.Spinal

Neck

a. Have you ever sustained a neck injury? Yes____ No____
   Explain____
   ____
b. How long after the injury were you permitted to resume play?
   Less than 2 days _____
   Less than 1 week _____
   Over 1 week _____
c. MD Name & #____
d. Do you wear any protective device such as a "horse collar" to reduce neck injury? Yes____ No____
e. Is you neck motion restricted in any way? Yes____ No____
   Explain____
f. Do you get any burning, numbness, tingling or shooting pains down your arms? Yes____ No____

Back

a. Have you ever injured your back? Yes____ No____

Sprain_______
Muscle strain__________
Disc problems__________
Unknown________________
Other_________________

b. How long after the injury were you permitted to resume play?
Less than 2 days _____
Less than 1 week _____
Over 1 week _____

c. MD name & #____

d. Were you instructed in special exercises? Yes____ No____
By whom?____

e. Do you get any burning, numbness, tingling or shooting pains down your legs? Yes____ No____

f. Was surgery recommended on your back/neck? Yes____ No____
Date__________ Side__________

g. Was the surgery performed? YES_____ NO_____ Date________

III.Knee

a. Have you ever had a knee injury? Yes____ No____
please give dates & side
Sprain________________________________
Dislocation___________________________
Cartilage_____________________________
Unknown_______________________________
Other_________________________________

b. Was surgery recommended on either knee? Yes____ No____
Date________ Side_______

c. Was the surgery performed? Yes____ No____ Date_____Side_____
Date_____Side_____

d. Doctor's Name & # ____

e. Were you given specific exercises following injury? Yes___No___
By whom?____

f. At the present time do either of your knees:
1.swell Yes____ No____ Side_____
2.lock up Yes____ No____ Side_____
3.give away Yes____ No____ Side_____
4.feel unstable Yes____ No____ Side_____
5.hurt after activity Yes____ No____ Side_____

IV.Shoulder

a. Have you ever had a Shoulder injury?
Yes____ No____
please give dates & side
Separation____________________________
Dislocation___________________________
Rotator cuff injury___________________
Tendinitis____________________________
Unknown_______________________________
Other_________________________________

b. Was surgery recommended on either shoulder? Yes____ No____
Date________ Side_______

c. Was the surgery performed? Yes____ No____ Date____ Side____
Date____ Side____

d. Doctor's Name & # _______________________________________

e. Were you given specific exercises following injury? Yes___No__
By whom?____

f. Does your shoulder "pop out" of place on a regular basis?____

V.Ankle

a. Have you ever had a ankle injury?
Yes____ No____
please give dates & side
Sprain _______________________________
Fracture______________________________
Torn Ligaments________________________

Unknown___________________________________
Other_____________________________________

b. Was surgery recommended on either ankle? Yes____ No____
Date________ Side________
c. Was the surgery performed? Yes____ No____ Date____
d. Doctor's Name & # _______________________________________
e. Were you given specific exercises following injury? Yes___No___
By whom?____
f. Are you a recurrent ankle sprainer? Which side? ______________
____
g. Do you normally get your ankle(s) taped and/or wear braces?
____

VI.Lower Leg

a. Have you ever had: Shin Splints_____________________________
Stress Fractures_________________________
Tendinitis_______________________________
Other____________________________________
b. Do you now, or have you ever worn orthotics (inserts for your shoes)? Yes____ No____
c. Doctor's Name & # _______________________________________
d. Were you given specific exercises following injury? Yes____No _____
By Whom? ____
e. Was surgery recommended on your lower leg? YES_____ NO____
Date___________ Side____________
g. Was surgery performed? YES_____ NO______ Date______________

VII.Foot

a. Have you ever had: Sore arches______________________________
Please give date & side
Bunion___________________________________
Fracture _________________________________
Sprain ___________________________________
Other ____________________________________
b. Doctor's Name & # ____
c. Were you given specific exercises following injury? Yes_____NO _____
By Whom? ____
d. Was surgery recommended on your foot? YES____ NO____
e. Was the surgery performed? YES____ NO____ Date_________ Side________

VIII.Arm/Elbow

a. Have you ever had an arm or elbow injury?
Yes____ No____
please give dates & side
Strain________________________________
Fracture______________________________
Dislocation___________________________
Sprain________________________________
Tendinitis____________________________
Calcium Deposits______________________
Unknown_______________________________
Other_________________________________
b. Was surgery recommended on either arm? Yes____ No____
Date________ Side________
c. Was the surgery performed? Yes____ No____ Date____
d. Doctor's Name & # _______________________________________
e. Were you given specific exercises following injury? Yes___No__
By Whom? ____

IX.Hand/Finger

a. Have you ever had a hand/finger injury?
Yes____ No____
please give dates & side
Fracture______________________________
Dislocation___________________________
Sprain________________________________
Tendinitis____________________________
Calcium Deposits______________________
Unknown_______________________________
Other_________________________________
b. Was surgery recommended on either hand? Yes____ No____
Date________ Side________
c. Was the surgery performed? Yes____ No____ Date____
d. Doctor's Name & # _______________________________________

e. Were you given specific exercises following injury? Yes___No__
By Whom? ____
f. Do you regularly dislocate your fingers? ____________________

X.Hip/Thigh

a. Have you ever had a hip/thigh injury? Yes ____ No ____

Please give Date and Side

Quad______________________________________
Hamstring_________________________________
Groin_____________________________________
Calcium deposits__________________________
Fracture__________________________________
Other ____________________________________

b. Was surgery recommended on either hip/thigh? Yes ____ No _____
c. Was the surgery performed? Yes _____ No _____ Date ________
d. Doctor’s Name & # ____
e. Were you given specific exercises following injury? Yes____ No ____
By Whom? ____

Have you had any other physical injuries not listed above? Please list including dates.____

____

____

____

Are you currently being treated for any physical injury? Please list the doctor's name and address.____

____

____

____

Are you currently or in the past year seen a Physical Therapist for rehabilitation? Yes_____ No _____
If Yes please explain and list name/phone number of the physical therapist

____

____

____

I hereby state that to the best of my knowledge the above medical history is complete and truthful. *I also understand that voluntary withholding of medical information could void payments by New Jersey City University's insurance carrier.*

Parent's Signature____________________________ Date ________________

Student's signature___________________________ Date ________________