

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: Ann Marie Stoebling, 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

Brothers Sisters

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

- Have you ever had a concussion? Yes _____ No _____
- How many? _____
- Have you ever had amnesia? Yes _____ No _____ How long _____
- Have you ever had an MRI or CAT scan associated with a concussion? _____ Date _____ Where _____
- Did you miss playing time, how much? _____

Unconsciousness

- Have you ever been knocked unconscious? Yes _____ No _____
- How long were you unconscious? Less than 1 minute _____
Less than 5 minutes _____
More than 5 Minutes _____
- Were you evaluated by a physician? Yes _____ No _____
Name _____
- Were you admitted to a hospital? Yes _____ No _____
Name _____
- How long after the injury were you permitted to resume play? Less than 2 days _____
Less than 1 week _____
Over 1 week _____

Nose

- Do you get nose bleeds? Yes _____ No _____
- Have you ever broken your nose? Yes _____ No _____
- Have you had nasal surgery, when? Yes _____ No _____ Date _____
MD name _____

Eyes

- Do you have any vision impairments that could impede participation? Yes _____ No _____ Explain _____

Ears

- Have you had cauliflower ear? Yes _____ No _____
- Do you have any hearing impairments that could impede participation? Yes _____ No _____ Explain _____

II. Spinal

Neck

- Have you ever sustained a neck injury? Yes _____ No _____
Explain _____
- How long after the injury were you permitted to resume play? Less than 2 days _____
Less than 1 week _____
Over 1 week _____
- MD Name & # _____
- Do you wear any protective device such as a "horse collar" to reduce neck injury? Yes _____ No _____
- Is your neck motion restricted in any way? Yes _____ No _____
Explain _____
- Do you get any burning, numbness, tingling or shooting pains down your arms? Yes _____ No _____

Back

- 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 Bunion _____
date & side 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 _____ Strain _____
please give Fracture _____
dates & side 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 _____ Fracture _____
please give Dislocation _____
dates & side 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 Quad _____
 Date and Hamstring _____
 Side 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 _____