

STATE UNIVERSITY OF NEW YORK – NEW PALTZ
STUDENT HEALTH CENTER

INTERIM HISTORY FOR RETURNING VARSITY ATHLETES

Name: _____

Phone: (Local) _____

The following information is vital to adequately screen and medically clear athletes for continued participation in their sport. The purpose of this form is to update each athlete's chart with significant information regarding injuries, medical conditions, symptoms of concern, and use of medication since the athlete's entrance physical exam.

Has anyone in your family developed heart problems or experienced sudden death before age 50? Yes _____ No _____

If yes: Relationship to you: _____

Nature of Problem: _____

History: In the **PAST YEAR**, have any of the following happened to you? (Answer all questions)

| | Y/N | If yes, explain | Still a Problem, Y/N |
|--|-------|-----------------|----------------------|
| 1. Hospitalized for any reason? | _____ | _____ | _____ |
| 2. Surgery of any kind? | _____ | _____ | _____ |
| 3. Significant injury (fracture, dislocation, etc)? | _____ | _____ | _____ |
| 4. Overuse Injury (sprain, strain, etc)? | _____ | _____ | _____ |
| 5. Recurrent back pain? | _____ | _____ | _____ |
| 6. Use of medications for more than 10 days? | _____ | _____ | _____ |
| 7. Are you currently taking any prescription medicine including birth control or over the counter medication or pills or using an inhaler? | _____ | _____ | _____ |
| 8. Allergic reaction to food, medication, or stinging insects? | _____ | _____ | _____ |
| 9. Passed out during or after exercise? | _____ | _____ | _____ |
| 10. Chest pain or dizziness during or after exercise? | _____ | _____ | _____ |
| 11. High blood pressure and/or high cholesterol? | _____ | _____ | _____ |
| 12. Irregular heartbeats? | _____ | _____ | _____ |
| 13. Significant head injury/knocked? Unconscious? | _____ | _____ | _____ |
| 14. Seizures? | _____ | _____ | _____ |
| 15. Any shortness of breath with exercise? Wheezing? | _____ | _____ | _____ |
| 16. Chronic or recurrent cough with exercise? | _____ | _____ | _____ |
| 17. Loss or decreased function of any organ? | _____ | _____ | _____ |
| 18. Have you had any illness lasting a week or more such as mono or a chronic recurring illness or infection? | _____ | _____ | _____ |
| 19. Have you had any blood disorders, including Sickle cell trait, anemia (low blood), blood clot, unusual bleeding, etc? | _____ | _____ | _____ |
| 20. Asthma/seasonal allergies that require medical treatment? | _____ | _____ | _____ |
| 21. Menstrual problems/irregularities? | _____ | _____ | _____ |
| 22. Recurrent heat exhaustion? | _____ | _____ | _____ |

- 23. New onset or unusual headaches? _____
- 24. Have you been treated or evaluated for an eating disorder? _____
- 25. Have you been treated, or encouraged to seek treatment for an alcohol or substance/drug abuse problem? _____
- 26. Any other significant illness or problems? _____
- 27. Are you taking any supplements, vitamins, or herbal remedies? _____
- 28. Caffeine Use _____
 Chewing tobacco _____
 Smoking tobacco _____
- 29. PREGNANCIES
 Number of pregnancies? _____
 Have you used steroids? _____
- 30. Have you used marijuana, ecstasy, narcotics Cocaine/crack or other drugs for non-medical reasons? _____

PLEASE READ AND SIGN BELOW:

- (A) I certify that the above information is accurate and complete to the best of my knowledge. I realize that falsification of the provider information is a violation of the honor code that could result in sanctioning by a hearing panel.
- (B) I give permission for the Certified Athletic Trainers (within the Athletic Department), Student Health Center Staff, and all consulting physicians, permission to exchange, written or orally, any information concerning any injuries or illness which effects my ability to participate in physical activities throughout the time in which I am an official student athlete at the State University of New York New Paltz College. Any change in this status must be made in writing by the student athlete and rendered to all parties concerned.

 Student Signature

 Social Security #

 Printed Name

 Sport

 Date

FR ____ SO ____ JR ____ SR ____