EKU Athletic Bands
Medical History Questionnaire

Date: _____/_____/_____

Student's name: _____
(last) (first) (middle) (nickname)

Date of birth: _____/_____/_____ Age: _____ Race: _____ Sex at birth: M / F
(month) (day) (year)

Social Security No: _____/_____/_____ Student ID: _____

Local address (apartment, dorm, etc.): _____
(street)

_____ _____ _____
(state) (city) (zipcode)

Cell phone: _____ - _____ - _____ Home phone: _____ - _____ - _____

E-mail address: _____

Section in band: ☐ Brass
☐ Color guard
☐ Drum major
☐ Maroonettes
☐ Twirlers
☐ Percussion
☐ Woodwinds

Year in school: ☐ Freshman
☐ Sophomore
☐ Junior
☐ Senior
☐ Other: _____

Emergency Contact 1:
Name: _____ Relationship to student: _____

Address _____
(street) (state) (city) (zipcode)

Cell phone: _____ - _____ - _____ Home phone: _____ - _____ - _____

E-mail address: _____

Emergency Contact 2:
Name: _____ Relationship to student: _____

Address _____
(street) (state) (city) (zipcode)

Cell phone: _____ - _____ - _____ Home phone: _____ - _____ - _____

E-mail address: _____

Name: _____ Date: _____

Name of Primary Care Physician: _____

Address _____
(street) (state) (city) (zipcode)

Business phone: _____ - _____ - _____

Family Medical History: Is there a history of any of the following in your immediate family?

Yes	No	Alcoholism/Drug Abuse
Yes	No	AIDS or HIV
Yes	No	Cancer
Yes	No	Diabetes
Yes	No	Epilepsy/Seizure Disorder
Yes	No	Heart Conditions
Yes	No	Hypertension
Yes	No	Hypotension
Yes	No	Mental Illness
Yes	No	Sickle Cell Trait/Disease
Yes	No	Stroke
Yes	No	Sudden death before age 50
Yes	No	Thyroid Disease

Personal Medical History: Do you have any of the following medical conditions?

Yes	No	Alcoholism/Drug Abuse
Yes	No	AIDS or HIV
Yes	No	Anemia
Yes	No	Asthma or Exercise-Induced Asthma (EIA)
Yes	No	Cancer
Yes	No	Diabetes
Yes	No	Epilepsy/Seizure Disorder
Yes	No	Frequent Headaches or Migraines
Yes	No	Heart Condition (please provide diagnosis below)
Yes	No	Hypertension
Yes	No	Hypoglycemia
Yes	No	Hypotension
Yes	No	Mental Illness (please provide diagnosis below)
Yes	No	Sickle Cell Trait/Disease
Yes	No	Thyroid Disease

Please list **ALL** medical conditions (including any checked above): _____

_____

_____

Name: _____ Date: _____

Please list any allergies: _____

_____

_____

Please list any medications you are currently taking: _____

_____

_____

Please list any supplements, vitamins, or minerals you are currently taking: _____

_____

_____

Please list any hospitalizations or surgeries from within the past 5 years: _____

_____

_____

Have you ever had a concussion? Yes No

If yes, how many? _____ Date of most recent concussion: _____

Did you lose consciousness with your concussion(s)? Yes No

How long were you restricted from activity? _____

How long did your symptoms last after your most recent concussion? _____

Did you have any memory problems because of your concussion(s)? Yes No

Were you cleared by a medical professional to return to activity? Yes No

Have you ever had a neck or spine injury? Yes No

If yes, please provide date(s) of neck/spine injury: _____

Were you transported to the hospital for the neck/spine injury? Yes No

Did you have an x-ray, CT, or MRI scan for neck/spine injury? Yes No

Did you have numbness, burning, or stinging in your arms or legs? Yes No

Did you complete physical or occupational therapy? Yes No

Were you cleared by a physician to return to activity? Yes No

Have you ever been diagnosed with a spinal defect? Yes No

If yes, please list diagnosis: _____

Have you ever had trouble with heat intolerance? Yes No

If yes, when was the most recent episode of heat intolerance? _____

Were you cleared by a medical professional to return to activity? Yes No

Name: _____ Date: _____

Have you ever had an organ removed? Yes No

Please list: _____

In the last 12 months, have you had any of the following tests performed for a heart condition?

- ☐ Electrocardiogram (EKG)
- ☐ Echocardiogram
- ☐ Treadmill Stress Test

In the last 12 months, have you been diagnosed with or treated for any of the following?

- ☐ Chicken Pox
- ☐ Covid
- ☐ Diphtheria
- ☐ Hepatitis
- ☐ Lyme Disease
- ☐ Malaria
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Small Pox
- ☐ STD/STI
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Whooping Cough
- ☐ Other infectious virus (please specify): _____

Do you use any of the following?

- ☐ Chewing Tobacco
- ☐ Snuff
- ☐ Smokeless Tobacco
- ☐ Cigarettes
- ☐ Cigars
- ☐ Pipe
- ☐ Vape
- ☐ Other: _____

Do you wear glasses or contact lenses? Yes No

Do you wear any dental appliances? Yes No

Do you have any implants? Yes No

Please list: _____

Do you wear any external hardware (i.e. insulin pump, hearing aid) Yes No

Please list: _____

Name: _____ Date: _____

For females only:

Do you have regular menstrual cycles? Yes No

Date of last menstrual cycle: ____/____/____

Do you have any of the following (check all that apply)?

- ☐ Absence of menstruation
- ☐ Decreased bone density
- ☐ Endometriosis
- ☐ Ovarian cysts
- ☐ Painful menstruation

Do you take birth control? Yes No

If yes, please specify which type (pill, IUD, implant, etc.): _____

Have you ever been pregnant? Yes No

If yes, please provide date(s) of pregnancy: _____

_____

If yes, list how many births and provide dates of births: _____

_____

Orthopedic History: have you ever fractured or dislocated the following body parts?

Yes	No	Hand	Fracture	Dislocation	Date:
Yes	No	Wrist	Fracture	Dislocation	Date:
Yes	No	Fingers	Fracture	Dislocation	Date:
Yes	No	Arm	Fracture	Dislocation	Date:
Yes	No	Shoulder	Fracture	Dislocation	Date:
Yes	No	Clavicle (collar bone)	Fracture	Dislocation	Date:
Yes	No	Neck	Fracture	Dislocation	Date:
Yes	No	Skull	Fracture	Dislocation	Date:
Yes	No	Rib	Fracture	Dislocation	Date:
Yes	No	Vertebrae	Fracture	Dislocation	Date:
Yes	No	Sacrum	Fracture	Dislocation	Date:
Yes	No	Coccyx (tail bone)	Fracture	Dislocation	Date:
Yes	No	Femur	Fracture	Dislocation	Date:
Yes	No	Leg	Fracture	Dislocation	Date:
Yes	No	Ankle	Fracture	Dislocation	Date:
Yes	No	Foot	Fracture	Dislocation	Date:
Yes	No	Toes	Fracture	Dislocation	Date:

Please list any orthopedic surgeries you have had: _____

_____

Name: _____ Date: _____

Mental Health Screening:

Have you ever been diagnosed with mental illness? Yes No

Please list any mental health diagnoses: _____

_____

Do you currently take any medications for a mental illness? Yes No

Patient Health Questionnaire-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better of dead or of hurting yourself in some way	0	1	2	3

Total: _____

Name: _____ Date: _____

General Anxiety Disorder Screening (GAD-7):

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total: _____

If you have any additional information you would like to provide, please us the space below:

_____

_____

_____

_____

_____

_____

All statements and answers in the above medical history questionnaire are true and complete to the best of my knowledge. I have no abnormality, limitation, or restriction not mentioned in this record. I understand that this information is to help determine my fitness to participate, and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur.

Printed name: _____Date:_____
(last) (first) (middle)

Signature: _____ Date:_____

Signature of parent/guardian: _____ Date:_____
(Not required if student is 18 years or older)