



University of Mary  
7500 University Drive, Bismarck, ND 58504  
(701) 355-8157 Fax: (701) 255-7687

**Student Athlete's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First MI

**Circle One:** Male / Female **Year in School:** FR SO JR SR 5th Yr SR **Sport(s):** \_\_\_\_\_

**Medical History Survey:** Please complete the following prior to your medical examination

Have you previously or do you currently have problems with:

**General Medical Conditions**

- |                            |     |    |
|----------------------------|-----|----|
| 1. Headaches               | Yes | No |
| 2. Heart                   | Yes | No |
| 3. Breathing               | Yes | No |
| 4. Asthma                  | Yes | No |
| 5. Abdominal Pain          | Yes | No |
| 6. Dizzy Spells/Black outs | Yes | No |
| 7. Eyes/Vision             | Yes | No |
| 8. Contact Lenses          | Yes | No |
| 9. Ears/Hearing            | Yes | No |
| 10. Kidneys                | Yes | No |
| 11. Bladder                | Yes | No |
| 12. Diabetes               | Yes | No |
| 13. High Blood Pressure    | Yes | No |
| 14. Cancer                 | Yes | No |
| 15. Skin Disorders         | Yes | No |
| 16. Eating Disorder        | Yes | No |
| 17. Sickle Cell Trait      | Yes | No |

**Orthopedic Conditions/Injuries**

- |                      |     |    |
|----------------------|-----|----|
| 18. Shoulders        | Yes | No |
| 19. Elbow/Wrist/Hand | Yes | No |
| 20. Hips             | Yes | No |
| 21. Knees            | Yes | No |
| 22. Ankles           | Yes | No |
| 23. Neck/Upper Back  | Yes | No |
| 24. Lower back       | Yes | No |

Have you ever been knocked unconscious? **Yes No**  
If yes, please explain \_\_\_\_\_

Have you missed practice/games due to a concussion? **Yes No**  
If yes, please explain and list dates \_\_\_\_\_

Have you ever experienced a neck injury? **Yes No**  
If yes, please explain \_\_\_\_\_

Are you under a physician's care at the present time? **Yes No**  
If yes, please and explain \_\_\_\_\_

Are you currently taking any medications or supplements? **Yes No**  
If yes, please list and explain \_\_\_\_\_

Do you have any drug, seasonal or environmental allergies?  
If yes, please explain \_\_\_\_\_

**Women:** Do you have a regular menstrual period? **Yes No**  
Date of last period: \_\_\_\_/\_\_\_\_/\_\_\_\_

Year of last tetanus \_\_\_\_\_

Please give details on all "yes" answers: \_\_\_\_\_

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I certify that the above information is accurate: \_\_\_\_\_  
Student-Athlete's Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

