



Rhodes College Orthopedic Health Questionnaire
(Please fill out the following questionnaire to the best of your knowledge)

Athlete's Name _____
Last Name First Name MI

Date _____

Sport (Primary) _____

Sport (Other) _____

HEAT ISSUES

1. Have you ever suffered from heat/muscle cramping? Yes No Date _____
Specify _____
2. Have you ever suffered from heat exhaustion? Yes No Date _____
Specify _____
3. Have you ever suffered from a heat stroke? Yes No Date _____
Specify _____
4. Have you ever had an IV due to heat problem? Yes No Date _____
Specify _____

HEAD AND NEUROLOGICAL MEDICAL HISTORY

1. Have you ever had a concussion (injury to the head)? If so how many times?
Yes No
Specify _____
2. Have you ever been knocked unconscious? If so how many times and for how long?
Yes No
Specify _____
3. Have you ever had long-term problems due to a head injury (i.e. memory loss, headaches, dizziness, nausea)?
Yes No
Specify _____
4. Have you ever had numbness, tingling, or weakness in the following areas?
 - a. Shoulders, arms, and/or hands Yes No Specify _____
 - b. Buttocks Yes No Specify _____
 - c. Legs and/or feet Yes No Specify _____
5. Have you ever had a burner or stinger (an injury causing a sudden burning pain and numbness down the arm and /or hand)?
Yes No
Specify _____
6. Have you ever had a seizure? Yes No Specify _____
7. Do you experience migraine headaches? Yes No
Specify _____

NECK MEDICAL HISTORY

Have you ever had or do you currently have a **NECK** injury or problem of the following?

- 1. Herniation Yes No Date _____
Specify _____
- 2. Traumatic Fracture Yes No Date _____
Specify _____
- 3. Whiplash Yes No Date _____
Specify _____
- 4. Stress Fracture Yes No Date _____
Specify _____

PHYSICIANS FINDINGS:

SPINE & BACK MEDICAL HISTORY

Have you ever had or do you currently have a **SPINE/BACK** injury or problem of the following?

- 1. Congenital Deformity Yes No Date _____
Specify _____
- 2. Traumatic Fracture Yes No Date _____
Specify _____
- 3. Stress Fracture Yes No Date _____
Specify _____
- 4. Back Pain or stiffness Yes No Date _____
Specify _____
- 5. Spondyloysis Yes No Date _____
Specify _____
- 6. Facet Disorder or Herniation Yes No Date _____
Specify _____
- 7. Sacroiliac Disorder Yes No Date _____
Specify _____
- 8. Sciatica Yes No Date _____
Specify _____
- 9. Scoliosis Yes No Date _____
Specify _____
- 10. Spondylolisthesis Yes No Date _____
Specify _____
- 11. Other, pain, swelling, or surgery Yes No Date _____
Specify _____

SHOULDER & CLAVICLE MEDICAL HISTORY

Have you ever had or do you currently have a **SHOULDER/CLAVICLE** injury or problem of the following?

- 1. Traumatic Fracture Yes No Date _____
Specify _____
- 2. Rotator Cuff Yes No Date _____
Specify _____
- 3. Subluxation or Dislocation Yes No Date _____
Specify _____
- 4. Bursitis or Impingement Yes No Date _____
Specify _____
- 5. Labral tear Yes No Date _____
Specify _____
- 6. Acromioclavicular (AC) Sprain or instability Yes No Date _____
Specify _____

7. Other, pain, swelling, or surgery Yes No Date _____
Specify _____

PHYSICIANS FINDINGS:

UPPER ARM, ELBOW, & FOREARM MEDICAL HISTORY

Have you ever had or do you currently have an **UPPER ARM, ELBOW, AND FOREARM** injury or problem of the following?

1. Traumatic Fracture Yes No Date _____
Specify _____
2. Elbow Dislocation Yes No Date _____
Specify _____
3. Tendon, Muscle, or Ligament Injury Yes No Date _____
Specify _____
4. Bursitis Yes No Date _____
Specify _____

HAND, WRIST, & FINGER MEDICAL HISTORY

Have you ever had or do you currently have a **HAND, WRIST, AND FINGER** injury or problem of the following?

1. Traumatic Fracture Yes No Date _____
Specify _____
2. Ligament or Tendon Injury Yes No Date _____
Specify _____
3. Dislocation Yes No Date _____
Specify _____
4. Other, pain, swelling, or surgery Yes No Date _____
Specify _____

THIGH, PELVIS & HIP MEDICAL HISTORY

Have you ever had or do you currently have a **PELVIS AND HIP** injury or problem of the following?

1. Traumatic Fracture Yes No Date _____
Specify _____
2. Stress Fracture Yes No Date _____
Specify _____
3. Tendonitis Yes No Date _____
Specify _____
4. Contusion or Hip Pointer Yes No Date _____
Specify _____
5. Dislocation Yes No Date _____
Specify _____
6. Groin Strain Yes No Date _____
Specify _____
7. Bursitis Yes No Date _____
Specify _____
8. Sports Hernia Yes No Date _____
Specify _____
9. Hamstring Strain Yes No Date _____
Specify _____
10. Quad Strain Yes No Date _____
Specify _____
11. Severe Contusion Yes No Date _____
Specify _____

12. Hip Labral Tear Yes No Date _____
Specify _____

PHYSICIANS FINDINGS:

KNEE MEDICAL HISTORY

Have you ever had or do you currently have a **KNEE** injury or problem of the following?

1. ACL Tear or Repair Yes No Date _____
Specify _____

2. MCL Tear or Repair Yes No Date _____
Specify _____

3. PCL Tear or Repair Yes No Date _____
Specify _____

4. LCL Tear or Repair Yes No Date _____
Specify _____

5. Meniscal Injury, Repair, Menisctomy Yes No Date _____
Specify _____

6. Dislocation of Patella Yes No Date _____
Specify _____

7. Patellar Femoral Syndrome Yes No Date _____
Specify _____

8. Patella Tendonitis Yes No Date _____
Specify _____

9. IT Band Syndrome Yes No Date _____
Specify _____

10. Swelling, pain, locking, instability or giving away? Yes No Date _____
Specify _____

ANKLE & LOWER LEG MEDICAL HISTORY

Have you ever had or do you currently have a **LOWER LEG** injury or problem of the following?

1. Traumatic Fracture Yes No Date _____
Specify _____

2. Stress Fracture Yes No Date _____
Specify _____

3. Muscle Strain Yes No Date _____
Specify _____

4. Shin Splints Yes No Date _____
Specify _____

5. Compartment Syndrome Yes No Date _____
Specify _____

6. Ankle Sprain Yes No Date _____
Specify _____

7. Ankle Tendonitis Yes No Date _____
Specify _____

8. Ankle Bone Chip in Joint Yes No Date _____
Specify _____

9. Ankle Dislocation Yes No Date _____
Specify _____

PHYSICIANS FINDINGS:

FOOT OR TOES MEDICAL HISTORY

Have you ever had or do you currently have a **FOOT OR TOES** injury or problem of the following?

1. Plantar Fasciitis Yes No Date _____
Specify _____

- 2. Dislocation Yes No Date _____
Specify _____
- 3. Bone Spur Yes No Date _____
Specify _____
- 4. Tendonitis Yes No Date _____
Specify _____
- 5. Sesmoiditis Yes No Date _____
Specify _____
- 6. Stress Fractures Yes No Date _____
Specify _____

PHYSICIANS FINDINGS:

ADDITIONAL ORTHOPEDIC MEDICAL INFORMATION

1. Please include surgeons name and a phone number for all orthopedic surgeries listed above.

- 1. Injury _____ Physician Name _____ Phone
(____) _____
- 2. Injury _____ Physician Name _____ Phone
(____) _____
- 3. Injury _____ Physician Name _____ Phone
(____) _____
- 4. Injury _____ Physician Name _____ Phone
(____) _____

3. Have you ever had a cortisone injection into a tendon, bursa, or a joint for an injury or pain?

Yes No Date _____

Specify _____

5. Please list any additional medical problems Rhodes College Training staff should be aware of:

- 1. _____
- 2. _____
- 3. _____

This form will be reviewed by the team physician and athletic training staff and placed in your permanent medical file at Rhodes College.

By signing below, I agree that this information is true and accurate to the best of my knowledge. I understand failure to disclose any or all medical problems and/or accurate medical history may result in forfeiture of my athletic aid, and relieves Rhodes College of any and all liability.

Signature: _____

Date: _____

Signature: _____

Date: _____

If under 18, Parents or Legal Guardian

Final Review by Athletic Trainer

Initial: _____