New Student Medical History Questionnaire

FIRST NAME: _____ LAST NAME: _____ MI: ____

SEX (CIRCLE): M F DATE OF BIRTH: ____/____/____ AGE: _____

ACADEMIC YEAR (CIRCLE): 1 2 3 4 5 CELL #: _____

SPORTS or ACTIVITIES: _____

Please answer all of the following questions. Please check either YES or NO for each question and then explain every YES answer in the space provided: THANK YOU.

GENERAL MEDICAL HISTORY

Please answer the following questions:

Hospitalization/Surgical history:

_____

_____

_____

Do you have a present or past history of: (check all that apply)

_____

- ☐ Alcohol abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Back Problems
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Cough (Chronic)
- ☐ Disability/Handicap
- ☐ Drug Abuse
- ☐ Gallbladder Trouble
- ☐ Hay Fever (Recurrent)
- ☐ Hepatitis/Jaundice
- ☐ Joint Disease/Injury
- ☐ Measles, Red
- ☐ Mononucleosis, Infectious
- ☐ Mumps
- ☐ Pneumonia
- ☐ Paralysis
- ☐ Polio
- ☐ Psychological Counseling
- ☐ Rheumatic Fever
- ☐ Rubella (3-day Measles)
- ☐ Scarlet Fever
- ☐ Sexually Transmitted Disease (STD)
- ☐ Sickle Cell Trait (Anemia)
- ☐ Sinus Trouble
- ☐ Sleep Problems
- ☐ Smoking/Tobacco use (how long?)
- ☐ Spleen, Surgical removal
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Urinary Tract Infection

If you answered **YES** to any of the above, please explain:

_____

_____

_____

Allergies:

Have you ever been diagnosed with any allergies (Medicines, Bee Stings, and/or Foods)? ☐ **Yes** ☐ **No**

- Please describe: _____

Have you ever carried an epi-pen for your allergy(s)? ☐ **Yes** ☐ **No**

- Please describe: _____

Are you currently taking/have you previously taken any allergy medications? ☐ **Yes** ☐ **No**

- Please describe: _____

Asthma:

Have you ever been diagnosed with Asthma and/or Exercise Induced Asthma? ☐ **Yes** ☐ **No**

- Please describe: _____

Are you currently taking/have you previously taken any allergy medications or used an inhaler? ☐ **Yes** ☐ **No**

- Please describe: _____

How many acute asthma attacks have you had in the past 24 months? ☐ **Yes** ☐ **No**

- Please describe: _____

Cardiovascular Risk Factors:

Does anyone in your family have a history of high blood pressure? ☐ **Yes** ☐ **No**
- Please describe: _____

Does anyone in your family have a history of high blood cholesterol? ☐ **Yes** ☐ **No**
- Please describe: _____

Has any family member or relative died of heart problems and/or sudden death before age 50? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you been diagnosed with high blood pressure? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you been diagnosed with high blood cholesterol? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you been diagnosed with a heart murmur? ☐ **Yes** ☐ **No**
- Please describe: _____

Has a physician ever denied or restricted your participation in sports due to any heart problems? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever been seen by a heart specialist (Cardiologist)? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever had an electrocardiogram (EKG) and/or an echocardiogram of your heart? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever had chest pain and/or shortness of breath during or after exercise/practice? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever felt dizzy, lightheaded, and/or passed out during or after exercise/practice? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever had the feeling of your heart racing or skipping beats during or after exercise/practice? ☐ **Yes** ☐ **No**
- Please describe:_____

Do you get tired more quickly than your teammates during exercise/practice? ☐ **Yes** ☐ **No**
- Please describe: _____

Diabetic History:

Have you ever been diagnosed with diabetes? ☐ **Yes** ☐ **No**
- Please describe: _____

Are you currently taking any diabetic medication? ☐ **Yes** ☐ **No**

Medication	Form	Dosage	Frequency

Do you monitor your blood sugar level daily? ☐ **Yes** ☐ **No**
- Please describe: _____

Please list any precautions that you take and/or additional information not listed above:

_____

_____

_____

Heat Related Problems:

Have you ever experienced heat cramps, heat exhaustion, and/or heat stroke? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever received intravenous fluids (IV) for a heat related problem? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever been hospitalized for a heat related problem(s)? ☐ **Yes** ☐ **No**
- Please describe: _____

Ear/Nose/Throat:

Do you have frequent ear infections and/or nosebleeds? _____ ☐**Yes** ☐**No**

Have you ever had an injury to your ear(s), nose, and/or throat? _____ ☐**Yes** ☐**No**
- Please describe: _____

Dermatological:

Do you have any skin conditions (i.e. itching, rash, acne, warts, eczema, fungus, etc.)? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever been under the care of a dermatologist for any condition? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever had MRSA or a staph infection? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever had herpes glaldatorium (mat herpes)? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever been advised not to participate in athletic activities due to a skin condition? ☐ **Yes** ☐ **No**
- Please describe: _____

Vision:

Do you routinely wear glasses? ☐ **Yes** ☐ **No**

Do you routinely wear contacts? ☐ **Yes** ☐ **No**

Do you wear any special devices or protective equipment? ☐ **Yes** ☐ **No**
- Please describe: _____

Is your color vision normal? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever had an eye injury? ☐ **Yes** ☐ **No**
- Please describe: _____

Dental:

Do you have a bridge or any false teeth? ☐ **Yes** ☐ **No**

Have you ever fractured a tooth or had a tooth knocked out? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever suffered any other type of injury to your mouth, jaw, and/or teeth? ☐ **Yes** ☐ **No**
- Please describe: _____

Abdomen:

Have you ever been diagnosed with a problem involving your stomach, abdomen, intestines, or rectum? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever had abdominal surgery? ☐ **Yes** ☐ **No**
- Please describe: _____

Do you have only one of two paired, functioning organs (kidney, testicles, ovaries, etc.)? ☐ **Yes** ☐ **No**
- Please describe: _____

Do you routinely suffer from severe or recurrent abdominal pain? ☐ **Yes** ☐ **No**
- Please describe: _____

Do you routinely suffer from chronic or recurrent diarrhea? ☐ **Yes** ☐ **No**
- Please describe: _____

Please list ALL prescription and over-the-counter medications, supplements, and/or performance aids that you are CURRENTLY taking or HAVE TAKEN in the past (12) months, and for what purpose:

Medication	Condition	Dosage	Date(s)

Fill out only ONE OF THE FOLLOWING boxes.

MALE Students

Have you ever had a testicular injury? ☐**Yes** ☐**No**
- If YES, when? _____

Have you ever been seen by a doctor for testicular pain? ☐**Yes** ☐**No**
- If YES, what for? _____

Do you feel pain or burning with urination? ☐**Yes** ☐**No**

Do you have blood in your urine? ☐**Yes** ☐**No**

Have you had any kidney, bladder, or prostate infections in the last 12 months? ☐**Yes** ☐**No**

Do you have any problems emptying your bladder completely? ☐**Yes** ☐**No**

Have you been diagnosed with:
- Hydrocele ☐**Yes** ☐**No**
- Varicocele ☐**Yes** ☐**No**
- Torsion ☐**Yes** ☐**No**

Have you ever had a hernia? ☐**Yes** ☐**No**
- If YES, please describe:

  _____

FEMALE Students

Have you had regular/monthly menstrual periods within the past 12 months? ☐**Yes** ☐**No**
- If NO, how many in the past year? _____
- When was your most recent menstrual period? _____

Do you take medications during your menstrual periods? ☐**Yes** ☐**No**
- If YES, what? _____

Have you had a pelvic examination within the last 12 months? ☐**Yes** ☐**No**

Have you ever been diagnosed with a stress reaction or fracture? ☐**Yes** ☐**No**

Do you feel you maintain healthy eating habits? ☐**Yes** ☐**No**
Have you had a weight change (gain or loss) of greater than 10lbs in the past 12 months? ☐**Yes** ☐**No**
Do you regularly lose weight to participate in your sport? ☐**Yes** ☐**No**
Do you want to weight more or less than you presently do? ☐**Yes** ☐**No**
Do you have a history of anorexia, bulimia, and/or other eating disorders? ☐**Yes** ☐**No**
- Please describe: _____

Do you feel stressed out? ☐**Yes** ☐**No**
Do you get the necessary support to deal with your stress? ☐**Yes** ☐**No**
Have you been diagnosed with a mental disorder? ☐**Yes** ☐**No**
- Please describe: _____

CONCUSSION HISTORY

Head Injuries/Concussion:

Have you ever suffered a head injury/concussion (no matter how minor)? ☐**Yes** ☐**No**
- How many? _____
- Dates: _____

Have you ever been evaluated by a physician for a head injury? ☐**Yes** ☐**No**
- Please describe: _____

Have you ever been hospitalized, become unconscious, and/or lost your memory from a head injury? ☐**Yes** ☐**No**
- Please describe: _____

Do you suffer from frequent headaches? ☐**Yes** ☐**No**
- How often? _____
- Please describe: _____

Do you have a history of migraine headaches? ☐**Yes** ☐**No**
- How often? _____
- Please describe: _____

Do you have a history of seizures? ☐**Yes** ☐**No**
- Please describe: _____

ORTHOPEDIC HISTORY

Have you ever injured (sprained, strained, dislocated, fractured, or had repeated swelling) any of the following:

		EXPLANATION
Head/Face	☐ **Yes** ☐ **No**	_____
Neck	☐ **Yes** ☐ **No**	_____
Chest	☐ **Yes** ☐ **No**	_____
Shoulder	☐ **Yes** ☐ **No**	_____
Elbow	☐ **Yes** ☐ **No**	_____
Wrist/Hand	☐ **Yes** ☐ **No**	_____
Thumb/Fingers	☐ **Yes** ☐ **No**	_____
Back	☐ **Yes** ☐ **No**	_____
Hip/Thigh	☐ **Yes** ☐ **No**	_____
Knee	☐ **Yes** ☐ **No**	_____
Lower Leg	☐ **Yes** ☐ **No**	_____
Ankle	☐ **Yes** ☐ **No**	_____
Foot/Toes	☐ **Yes** ☐ **No**	_____

Have you ever been diagnosed with a stress reaction or fracture? ☐ **Yes** ☐ **No**

- Please describe: _____

Name any recent injuries or illnesses within the last 18 months that resulted in surgery, hospitalization, or loss of participation:

_____

_____

PROVIDER COMMENTS:

_____

_____

_____

_____

_____

_____

The following pertains to Benedictine Athletics only:

ANY OF THE PRECEEDING CONDITIONS REQUIRE A LETTER FROM YOUR ATTENDING PHYSICIAN CLEARING YOU FROM THE INJURY OR DISORDER BEFORE YOU ARE ALLOWED TO PARTICIPATE:

A) Heart murmurs and heart abnormalities

B) Bone and joint surgeries performed within one year of participation at BC

C) Any medical illness or disease which limits physical participation

I do hereby state that, to the best of my knowledge and belief, the medical history and information that I have provided is complete and accurate. I further understand that any medical information withheld, incomplete, or incorrect discharges Benedictine College from all medical and legal liability and may disqualify me from participating in intercollegiate athletics at Benedictine College. I authorize Benedictine Student Health Center and/or Benedictine Sports Medicine to provide medical services, immunizations, therapeutic services to the above named student as may be necessary, and if needed, to refer to private care when special service is indicated.

_____ _____

Student Signature Date

_____ _____

Parent/Guardian's Signature ***(if under 18 years of age)*** Date

_____

Parent/Guardian's Print Name

REQUIRED IMMUNIZATIONS AND TUBERCULOSIS SCREENING

The Benedictine College policy **REQUIRES** that all newly admitted or admitted students born after January 1, 1957 show proof of TWO vaccinations for Measles, Mumps, Rubella, show proof of Meningitis vaccine and complete the tuberculosis screening process stated below. Failure to do so will result in being place on administrative hold and blocked from enrollment in the following semester. History of Measles is NOT acceptable. Please submit one of the following:

- This personal record completed by a healthcare giver
- A Physician or clinic report
- A copy of your school immunization record
-

A. REQUIRED MMR (measles, mumps, rubella) Date 1st _____/_____/_____ 2nd _____/_____/_____

Or: Measles 1st _____/_____/_____ 2nd _____/_____/_____ or date of Immune Titer_____

And Mumps 1st _____/_____/_____ Or date disease confirmed by physician_____ Ordate of Immune Titer_____

And Rubella 1st_____/_____/_____ Or date of Immune Titer_____ (clinical history NOT acceptable for Rubella)

B. REQUIRED TUBERCULOSIS SCREENING (All students must answer the following questions) **WRITE YES OR NO**

_____You are from or have lived for 2 months or more in Africa, Mexico, Central or South America, the Caribbean, Oceania/Pacific Islands, Asia, Indian Subcontinent, Middle East, or Eastern Europe & N.I.S. (circle those that apply)
_____Hove you had any of the following symptoms for more than two weeks? Persistent cough, bloody sputum, night sweats, fever, weight loss, or loss of appetite. (circle those that apply)
_____You have been diagnosed with a chronic medical condition that may impair your immune system.
_____Have you had a recent known exposure to Tuberculosis?
_____You are a healthcare worker.
_____You are a volunteer or employee of a nursing home, prison, or other residential institution.

If any of the above applies, the following is required:
***Screening:** Come to Student health for a free Tuberculosis skin test during hours posted at ext. 7117 after arrival to campus.
OR provide documentation of PPD mantoux skin tests done in the US within the past 12 months: date given___date read___ Result in m.m. of induration_____
(International students: provide date given if BCG given_____/_____/_____)
***Chest X-Ray:** Chest s-rays will be required for anyone with a positive skin test. X-rays will be taken at the Atchison Hospital. Or you may submit an x-ray report taken within the last 12 months, if history of positive PPD. Date of positive PPD___/___/___
***Treatment:** A student with a positive skin test will be referred for follow up for possible treatment. If you have been treated for TB infection or disease, please provide documentation.

C. REQUIRED MENINGITIS VACCINE….._____/_____/_____

D. REQUIRED TETANUS/DIPTHERIA: Completed primary series of tetanus/diphtheria immunizations (DtaP or DTP)….

#1_____/_____/_____#2_____/_____/_____#3_____/_____/_____#4_____/_____/_____#5_____/_____/_____

E. REQUIRED TETANUS/DIPTHERIA BOOSTER within the last 10 years…..____/_____/_____

HIGHLY RECOMMENDED IMMUNIZATIONS
HEPATITIS B…….#1_____#2_____#3_____
VARICELLA (if not immune to chicken pox)…#1_____#2_____or date if immune titer_____
INFLUENZA (available in the fall on campus)…._____ _____ _____
OTHER……..____/_____/_____

Medical Provider (must be one of the following): ☐ MD ☐ Physicians Assistant ☐ Nurse Practitioner

_____

Signature **Print Name** **Telephone Number**

Address_____

STATEMENT OF EXEMPTION TO IMMUNIZATIN LAW:
If your personal or religious beliefs or specific medical condition preclude inoculation, you must sign one of the following waivers. Pregnancy is justification for temporary medical exemption. Are you pregnant?_____. In the event of an outbreak, exempted persons will be subject to exclusion from school and quarantine. No reimbursement of tuition will be provided.

MEDICAL EXEMPTION: The physical condition of the above named person is such that immunization would endanger life or health, or is medically contraindicated due to other medical conditions.
Medical professional signature_____Business Phone_____Date_____

RELIGIOUS/PERSONAL EXEMPTION: Parent or guardian of the above named person or the person himself/herself adheres to a religious or personal belief opposed to immunizations. (Parent must sign if the student is under 18 years old)
Student's signature_____Parent/Guardian Signature_____Date_____