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

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
  - Please describe:

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<tr>
<th>Medication</th>
<th>Form</th>
<th>Dosage</th>
<th>Frequency</th>
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- 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:

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<th>Medication</th>
<th>Condition</th>
<th>Dosage</th>
<th>Date(s)</th>
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</table>
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?
  • 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?

Do you have any problems emptying your bladder completely?

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?
  • Please describe: ____________________________

Have you ever been hospitalized, become unconscious, and/or lost your memory from a head injury?
  • Please describe: ____________________________

Do you suffer from frequent headaches?
  • How often? ____________________________
  • Please describe: ____________________________

Do you have a history of migraine headaches?
  • How often? ____________________________
  • Please describe: ____________________________

Do you have a history of seizures?
  • Please describe: ____________________________

□ Yes □ No
## ORTHOPEDIC HISTORY

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

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Yes</th>
<th>No</th>
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<td>Head/Face</td>
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### EXPLANATION

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<th>Explanations</th>
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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 PRECEDING 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 placed 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 date of Immune Titer

Or: Measles 1st / / 2nd / / or date of Immune Titer
And Mumps 1st / / Or date disease confirmed by physician
And Rubella 1st / / Or date of Immune Titer

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)
- 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 have been treated for TB infection or disease, please provide documentation.

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 X-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, please provide documentation.

C. REQUIRED MENINGITIS VACCINE

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

E. REQUIRED TETANUS/DIPHTHERIA 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)... #1 #2 #3 #4 #5

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/PERSOAL 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