

**Athlete Name**

**Date**

**Memory Jogger-SIU Athletes**  
**Please check appropriate answer**

**Family History:**

Diabetes	Yes	No	Whom:	Comments:
Allergies	Yes	No	Whom:	
Migraines	Yes	No	Whom:	
Heart trouble	Yes	No	Whom:	
High Blood Pressure	Yes	No	Whom:	
Sudden Death in the family under the age of 50?	Yes	No	Please explain:	

**Have YOU had or do YOU now have:**

	YES	NO	Date of Injury		YES	NO	Date of Injury
Concussion				Impaired Vision			
Loss of consciousness				Perforated ear drum			
Skull fracture				Discharge from ear or infections			
Convulsions/ Epilepsy				Sinus infections			
Neck Injury				Dental plate or dentures			
Burner/Stinger Or numbness in neck, shoulder/arm				Orthodontic repair			
Tendency to bleed or bruise excessively				Pneumonia			
Functioning of only one paired organ				Infectious disease, i.e. mono or hepatitis			
Hernia				Diabetes			
Blood in urine				Anemia			
Weight problems				STD's			

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**Have YOU had or do have:**

	YES	NO	Date of Injury		YES	NO	Date of Injury
Asthma				Allergies			
If yes, Do you use inhalers? Name _____				If yes, please explain and MEDs used for your problem: Seasonal/Hay fever-  Bee Sting-  Medication-			
	YES	NO	Date of Injury		YES	NO	Date of Injury
Fungus infection				Athletes' foot			
Hives or rash				Recurrent boils			
Comments:							

**Do YOU use or take:**

	YES	NO	Date began use		YES	NO	Date began use
Smokeless tobacco				Nutritional supplements			
Cigarettes				Vitamins			
Medications or Prescriptions				Performance Supplements			
If yes to medications/RX:  Name _____ Explain for condition:				If yes to supplements:  Name _____ Explain for condition:			

**NOTE:** Please inform us if you are taking medications, and/or change medications, as the Athletic Training Staff will need to have notification of such prescriptions and/or over the counter medications for proper care and NCAA institution awareness for drug testing. In addition, if you are taking nutritional supplements and/or performance enhancements, refer to the SIU Drug and Alcohol Abuse Policy.

Athlete Name \_\_\_\_\_ Date \_\_\_\_\_

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**Confidential Women's and Men's Health History**

**Women:**

**Men:**

	YES	NO			YES	NO	
Menstrual problems			Age of menses:	Testicular Exam			
Gynecological exam (yearly)			Date of last:				
Breast Exam (monthly)							
Sexually Transmitted Infections			Need Referral: Yes _____ No _____	Sexually Transmitted Infections			Need Referral: Yes _____ No _____

**NOTE:** If at any time, questions on female and male reproductive systems, the Athletic Training Staff can refer you to an expertise for answers. Remember, this is confidential and does not leave your file.

**Have you had or do you now have:**

	YES	NO	
Do you experience frequent anxiety?			If yes, please explain:
Have you ever been treated for emotional problems?			If yes, please explain:
Have you ever been told to give up athletics for health problems?			If yes, please explain:

**NOTE:** SIU offers counseling services. If you need further assistance, a referral can be made for you to use services on campus or off campus.

**ATC Comments:**

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Athlete Name \_\_\_\_\_ Date \_\_\_\_\_

**SALEM INTERNATIONAL UNIVERSITY-MEDICAL ROLE STATEMENT**

**Do you have any other additional conditions or comments that have not been addressed thoroughly in the above questionnaire? Please use space below to describe.**

The undersigned, herewith,

- Understands that any medical expense incurred due to the above pre-existing conditions and not directly attributable to athletic participation at SIU is their personal responsibility.
- Understands that he or she must refrain from practice while ill or injured, whether or not receiving medical treatment, and during medical treatment until he or she is discharged from treatment or is given permission by the clinical practitioner to restart participation despite continuing treatment.
- Understands that having passed the physical examination does not necessarily mean that he or she is physically qualified to engage in athletics, but only that the evaluator did not find a medical reason to disqualify him or her at the time of said examination.
- Certifies that the answers above are correct and true.

Printed Name of Athlete \_\_\_\_\_

SSN/International # \_\_\_\_\_ Sport(s) \_\_\_\_\_

Athlete Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Guardian (if minor) \_\_\_\_\_ Date \_\_\_\_\_

REVIEWED BY ATC \_\_\_\_\_ DATE \_\_\_\_\_