NEW STUDENT-ATHLETE MEDICAL HISTORY FORM

Student-Athlete Information

Name ________________________                     Date ________________________

Date of Birth ________________________ SSN ________________________

Student ID Number ________________________

Personal Physician's Name ________________________

Sport ________________________                     Page 1

Academic Class ________________________

Phone # ________________________

Person to Contact In The Event of Emergency

Name ________________________                     Relationship ________________________

Home Phone Number ________________________ Cell Phone Number ________________________

Immunization History

Please list the when you have received the following immunizations.

MMR ________________________ Tetanus ________________________

Family History

Do you have any family members under 50 years old who died suddenly? Please explain and indicate how you are related.

_________________________________________________________________________________________________________________________________________________________________________

_________________________________________________________________________________________________________________________________________________________________________

_________________________________________________________________________________________________________________________________________________________________________

Does anyone in your family have any of the following medical problems? Circle all that apply.

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertrophic cardiomyopathy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dilated cardiomyopathy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arrhythmogenic right ventricular cardiomyopathy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catecholaminergic polymorphic ventricular tachycardia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brugada syndrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marfan syndrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long QT syndrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short QT syndrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aneurysm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Trait</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please list any additional relevant medical conditions that your mother, father, and/or grandparents may have had or currently have that has not been previously answered.

_________________________________________________________________________________________________________________________________________________________________________

_________________________________________________________________________________________________________________________________________________________________________

Updated 5/2014
Personal Medical History

Allergies

Please list all allergies that you have to any drug, medication, food, plant, insect bite/sting, etc.

Have you ever had an allergic reaction that required medical attention?

Medications

Please list all medications that you are currently taking and what dosage? (please include inhalers, birth control medications, etc.)

Nutritional Supplements

Please list all nutritional supplements that you are currently taking?

Cardiovascular History

(Please Circle)

Have you ever had chest pain and/or shortness of breath during or after exercise/practice? Yes No

Have you ever passed out during or after exercise? Yes No

Have you ever had the feeling of your heart pounding, racing, or skipping beats during exercise? Yes No

Have you ever had the feeling of your heart pounding, racing, or skipping beats at rest? Yes No

Have you ever been told by a physician that you have a heart condition, disease, or defect? Yes No

Have you ever been told you have a heart murmur or abnormal heart rhythm? Yes No

Has a physician ever denied or restricted your participation in sports due to heart problems? Yes No

Have you ever had an electrocardiogram (EKG) of your heart? Yes No

Have you ever had an echocardiogram of your heart? Yes No

Have you ever performed a treadmill or stationary bike stress test? Yes No

Have you ever been diagnosed by a physician with high blood pressure? Yes No

Have you ever been told that you have high cholesterol? Yes No

If you answered “yes” to any question above, please explain in the lines below.
Allergy and Asthma History

Have you ever needed allergy medication on a daily basis?  Yes  No
Have you ever had a hives?  Yes  No
Have you ever been diagnosed by a physician with asthma?  Yes  No
Have you ever been diagnosed by a physician with exercise induced asthma?  Yes  No
Have you previously used an inhaler?  Yes  No
Are you presently using an inhaler?  Yes  No
Have you ever taken a steroid based medication to control your asthma?  Yes  No
Are you presently taking a steroid based medication to control your asthma  Yes  No

If you answered "yes" to any question above, please explain in the lines below.


Diabetic History

Have you ever been diagnosed by a physician with diabetes?  Yes  No

(if you answered “No,” please proceed to the next section)

How often do you check your blood sugar levels on a daily basis?  

Are you presently taking any medications to control your diabetes?  Yes  No

If “yes” please list medications here:

Please list all information regarding your diabetes, including, type of diabetes, method of control, precautions that you take, medications that you will travel with, etc.


Heat Illness History

Have you ever been removed from practice or competition for any heat related illness?  Yes  No
Have you ever taken or currently taking any substance to prevent heat cramps?  Yes  No

If “yes”, what are you taking?

If you answered “yes” to any question above, please explain in the lines below.


Vision and Auditory History

What is the date of your most recent eye exam

Do you regularly wear glasses or contacts for daily living? Yes No

Do you wear glasses or contacts for athletic activity? Yes No

If yes, please list your prescription: Right__________________________ Left__________________________

Have you ever been diagnosed with a hearing impairment by a physician? Yes No

Do you regularly wear hearing aids or use any other auditory enhancement device? Yes No

If you answered “yes” to any question above, please explain in the lines below.

Mental Health History

Have you ever been diagnosed with any of the following mental health conditions?

Depression Yes No

Anxiety Yes No

Seasonal affective disorder Yes No

Post traumatic stress disorder Yes No

Bi-polar disorder Yes No

Eating disorder Yes No

Other mental health condition not previously listed Yes No

Concussion History

Have you ever had a concussion that was diagnosed by a physician or athletic trainer? Yes No

If “no”, please proceed to next section

List the dates of concussions you have had:

Have you ever been referred to the emergency room for a concussion? Yes No

Have you ever been hospitalized for a concussion? Yes No

Have you ever lost consciousness from a head injury? Yes No

Have you ever had a head injury that caused you to be confused or unsteady on your feet? Yes No

Have you ever had a head injury that caused you to have headache, nausea, or dizziness? Yes No

Have you experienced signs and symptoms from a head injury that lasted for more than two weeks? Yes No

Updated 5/2014
Have you ever missed class or postponed assignments/tests due to a head injury?  

Yes  No

If you answered “yes” to any of the previous questions, please provide further detail below including the dates of the concussion, grade of concussion, duration of symptoms, amount of time that you were held from participation, etc.

Other Medical Conditions

Are you missing or do you have impaired function of a paired organ (eye, kidney, lung, testicle etc)?  
Yes  No

Have you ever had an injury/illness to an internal organ?  
Yes  No

Have you ever been diagnosed with a hernia or sports hernia?  
Yes  No

Have you had any surgeries for non-orthopedic related conditions?  
Yes  No

If you answered “yes” to any question above, please explain in the lines below including dates.

Orthopedic History

For the body parts listed below, please indicate any sprains (injuries to ligaments), strains (injuries to muscles or tendons), fractures, dislocations, stress fractures, or other orthopedic injuries that you have experienced. Please be as specific as possible.

Upper Extremity (Shoulder, Upper Arm, Elbow, Forearm, Wrist, Hand, Fingers)

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Side of Body</th>
<th>Injury</th>
<th>Date of Injury</th>
<th>Date of Surgery</th>
<th>Treatment &amp; Rehab</th>
<th>Time Missed</th>
<th>Ongoing Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Updated 5/2014
**Lower Extremity (Hip, Thigh, Knee, Lower Leg, Ankle, Foot, Toes)**

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Side of Body</th>
<th>Injury</th>
<th>Date of Injury</th>
<th>Date of Surgery</th>
<th>Treatment &amp; Rehab</th>
<th>Time Missed</th>
<th>Ongoing Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Thorax (Neck, Chest, Ribs, Abdomen, Back)**

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Side of Body</th>
<th>Injury</th>
<th>Date of Injury</th>
<th>Date of Surgery</th>
<th>Treatment &amp; Rehab</th>
<th>Time Missed</th>
<th>Ongoing Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Medical Conditions Not Previously Noted**

Have you ever been tested for sickle cell trait?

If "yes", what was the result of the test?

Pos    Neg

Do you currently have or have you ever had any injury, illness, or medical condition not previously noted?

Yes    No

Updated 5/2014
UNIVERSITY OF PORTLAND SPORTS MEDICINE

Are you currently under a physician's care for any injury, illness, or medical condition not previously noted?  
Yes  No

Have you ever been told by a physician to restrict your activity or not participate in sports?  
Yes  No

Are you aware of any reason why you should not be allowed to participate in athletics?  
Yes  No

Is there anything that you would like to discuss with a University of Portland Team Physician?  
Yes  No

Upon your arrival to campus, is there anything that you would like to discuss with another healthcare professional such as a nutritionist, sport psychologist, etc.?  
Yes  No

If you answered "yes" to any question above, please explain in the lines below.

Statement of Confidentiality and Accuracy

I understand the information in this record will be used to determine my fitness for participation in intercollegiate athletics and to aid in the care and treatment of future injuries and illnesses that I may sustain. I attest that the responses given above are true, complete, and accurate to the best of my knowledge. I attest that no answers or information have been withheld. I attest that I have no abnormality, limitation, or restriction not mentioned in this record. I understand that if any information and/or statements are false and/or omitted in reference to my past and/or present medical history, then the University of Portland, it employees, agents, and representatives cannot be held liable for any injuries and/or illnesses that I have failed to disclose properly. I authorize the University of Portland Sports Medicine staff to render any first aid or emergency medical care. I further authorize the University of Portland Sports Medicine Staff to provide this medical information to other health care professionals to aid in the treatment of any medical problems that I may incur while participating as a student-athlete at the University of Portland. By signing this statement, I am confirming that it accurately reflects my wishes, and the responses given above are true, complete, and accurate to the best of my knowledge.

Student Athlete Signature ___________________________  Date ___________

Parent/Guardian Signature ___________________________  Date ___________

(If student-athlete is under 18 years of age)

Updated 5/2014