UNIVERSITY OF PORTLAND SPORTS MEDICINE

NEW STUDENT-ATHLETE MEDICAL HISTORY FORM

Student-Athlete Information

Name_____ Date_____

Date of Birth_____ SSN_____ Sport_____

Student ID Number_____ Academic Class_____

Personal Physician's Name_____ 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.

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

Hypertrophic cardiomyopathy	Yes	No	Long QT syndrome	Yes	No
Dilated cardiomyopathy	Yes	No	Short QT syndrome	Yes	No
Arrythmogenic right ventricular cardiomyopathy	Yes	No	Stroke	Yes	No
			Heart Attack	Yes	No
Catecholaminergic polymorphic ventricular tachycardia	Yes	No	Aneurysm	Yes	No
			Hypertension	Yes	No
Brugada syndrome	Yes	No	Sickle Cell Trait	Yes	No
Marfan syndrome	Yes	No	Diabetes	Yes	No

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.

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Personal Medical History

Allergies

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

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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.)

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Nutritional Supplements

Please list all nutritional supplements that you are **currently** taking?

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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.

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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.

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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.

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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.

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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.

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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

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)

Body Part	Side of Body	Injury	Date of Injury	Date of Surgery	Treatment & Rehab	Time Missed	Ongoing Issue

Lower Extremity (Hip, Thigh, Knee, Lower Leg, Ankle, Foot, Toes)

Body Part	Side of Body	Injury	Date of Injury	Date of Surgery	Treatment & Rehab	Time Missed	Ongoing Issue

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

Body Part	Side of Body	Injury	Date of Injury	Date of Surgery	Treatment & Rehab	Time Missed	Ongoing Issue

Medical Conditions Not Previously Noted

Have you ever been tested for sickle cell trait? Yes No

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

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.

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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 injures 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)