

MEDICAL HISTORY

University of Dayton Sports Medicine

Name _____ Sex _____ Age _____ Date _____
 Home Address _____ City _____ State _____ Zip _____
 Parent or Guardian _____ Phone _____
 Yr. _____ Sport(s) _____ Date of Birth _____
 Family Physician _____ Address _____
 Physician's Phone _____ City _____ State _____ Zip _____

Explain "Yes" answers below.

- | | | | | | | | | | | | | | | | | | | | |
|--|---|-----------|-------|-----|------|---------|-------|------|-------|------|-------|------|-----------|----------|--------|-------|-----------|--|------|
| <p>Yes No</p> <p>1. Have you had a medical illness or injury since your last check up or sports physical?
Do you have an ongoing or chronic illness?</p> <p>2. Have you ever been hospitalized overnight?
Have you ever had surgery?</p> <p>3. Are you currently taking any prescription or non prescription (over-the-counter) medications or pills or using an inhaler?
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?</p> <p>4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?
Have you ever had a rash or hives develop during or after exercise?</p> <p>5. Have you ever passed out during or after exercise?
Have you ever been dizzy during or after exercise?
Have you ever had chest pain during or after exercise?
Do you get tired more quickly than your friends do during exercise?
Have you ever had racing of your heart or skipped heartbeats?
Have you had high blood pressure or high cholesterol?
Have you ever been told you have a heart murmur?
Has any family member or relative died of heart problems or of sudden death before age 50?
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?
Has a physician ever denied or restricted your participation in sports for any heart problems.</p> <p>6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?</p> <p>7. Have you ever had a head injury or concussion?
Have you ever been knocked out, become unconscious, or lost your memory?
Have you ever had a seizure?
Do you have frequent or severe headaches?
Have you ever had numbness or tingling in your arms, hands, legs, or feet?
Have you ever had a stinger, burner, or pinched nerve?</p> <p>8. Have you ever become ill from exercising in the heat?</p> <p>9. Do you cough, wheeze, or have trouble breathing during or after activity?
Do you have asthma?
Do you have seasonal allergies that require medical treatment?</p> | <p>Yes No</p> <p>10. Do you use any special protective or corrective equipment or devices that are not usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your tooth, hearing aid)?</p> <p>11. Have you had any problems with your eyes or vision?
Do you wear glasses, contacts, or protective eyewear?</p> <p>12. Have you ever had a sprain, strain, or swelling after injury?
Have you broken or fractured any bones or dislocated any joints?
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?</p> <p style="text-align: center;"><i>If yes, check appropriate box and explain below.</i></p> <table border="0" style="width: 100%; text-align: center;"> <tr> <td>Head</td> <td>Elbow</td> <td>Hip</td> </tr> <tr> <td>Neck</td> <td>Forearm</td> <td>Thigh</td> </tr> <tr> <td>Back</td> <td>Wrist</td> <td>Knee</td> </tr> <tr> <td>Chest</td> <td>Hand</td> <td>Shin/calf</td> </tr> <tr> <td>Shoulder</td> <td>Finger</td> <td>Ankle</td> </tr> <tr> <td>Upper Arm</td> <td></td> <td>Foot</td> </tr> </table> <p>13. Do you want to weigh more or less than you do now?
Do you lose weight regularly to meet weight requirements for your sport?</p> <p>14. Do you feel stressed out?</p> <p>15. Record the dates of your most recent immunizations (shots) for:
 Polio _____ Tetnus _____
 Hepatitis B _____ Chickenpox _____
 Measles _____ MCV4 (Meningitis) _____</p> <p>FEMALES ONLY</p> <p>16. When was your first menstrual period? _____
 When was your most recent menstrual period? _____
 How much time do you usually have from the start of one period to the start of another? _____
 How many periods have you had in the last year? _____
 What was the longest time between periods in the last year? _____</p> <p>Explain "Yes" Answers: _____

 _____</p> | Head | Elbow | Hip | Neck | Forearm | Thigh | Back | Wrist | Knee | Chest | Hand | Shin/calf | Shoulder | Finger | Ankle | Upper Arm | | Foot |
| Head | Elbow | Hip | | | | | | | | | | | | | | | | | |
| Neck | Forearm | Thigh | | | | | | | | | | | | | | | | | |
| Back | Wrist | Knee | | | | | | | | | | | | | | | | | |
| Chest | Hand | Shin/calf | | | | | | | | | | | | | | | | | |
| Shoulder | Finger | Ankle | | | | | | | | | | | | | | | | | |
| Upper Arm | | Foot | | | | | | | | | | | | | | | | | |

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct

Signature of athlete _____ Signature of parent/guardian _____ Date _____

