

**Florida Atlantic University Athletic Medical History**

Please type or print in black ink. Please fill out the medical history completely. Do not leave blanks.

**Personal information:**

Date: \_\_\_\_\_ Sport: \_\_\_\_\_

Name: \_\_\_\_\_  
Last Middle First

Social Security Number \_\_\_\_\_ Date of birth: \_\_\_\_\_

Please circle one for each of the following:

Academic Status: F So Jr Sr Transfer: Yes or No Sex: M F

Home (permanent) address:

Street Apt #

City State Zip

Country Home telephone number

Local address:

Street Apt #

City State Zip

Local telephone Number Cellular Phone Number

Email address: \_\_\_\_\_

List two emergency contacts: (One must be someone other than parent/guardian)

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number (Home) \_\_\_\_\_ (Work/Cell) \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number (Home) \_\_\_\_\_ (Work/Cell) \_\_\_\_\_

**Family history:**

Has anyone in your immediate family had any of the following:  
Please circle yes or no.

Heart disease	Yes	No	Diabetes	Yes	No
High blood pressure	Yes	No	Cancer	Yes	No
Stroke	Yes	No	Tuberculosis	Yes	No
Sudden Death (before age 50)	Yes	No	Asthma	Yes	No
Epilepsy	Yes	No	Gout	Yes	No
Migraine Headaches	Yes	No	Mental illness	Yes	No
Eating disorder	Yes	No	Sickle cell	Yes	No
Marfan's Syndrome	Yes	No	Drug/alcohol abuse	Yes	No

Explain all "Yes" answers \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Personal history:**

1. Have you ever been hospitalized? Yes No
  2. Have you ever had surgery? Yes No
  3. Do you have a pin, screw, or plate in any part of your body due to surgery? Yes No
  4. Are you presently under a doctor's care? Yes No
- Please explain and give dates of "Yes" answers: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Please list any medications you are currently taking and for what conditions.  
\_\_\_\_\_
6. Please list any known allergies \_\_\_\_\_  
\_\_\_\_\_

7. Have you ever had a head injury? (i.e., Concussion) Yes No
  8. Have you ever been knocked out or unconscious? Yes No
  9. Have you ever had a seizure, "fit", or epilepsy? Yes No
  10. Have you ever had a stinger, burner, or pinched nerve? Yes No
  11. Have you ever had numbness or tingling in your arms or legs? Yes No
- Please explain and give dates for "Yes" answers to Questions 7-11: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. Have you ever sprained, strained, dislocated, fractured, or had repeated swelling or other injuries of any bones, joints, muscles and tendons?  

<i>Body part</i>	<i>Yes or No</i>	<i>Explain and give dates</i>
Face/head/neck	Yes No	_____
Shoulder	Yes No	_____

Arm, elbow, forearm	Yes	No	_____
Wrist, hand, fingers	Yes	No	_____
Back	Yes	No	_____
Hip	Yes	No	_____
Thigh	Yes	No	_____
Knee	Yes	No	_____
Shin/calf	Yes	No	_____
Ankle, foot, toes	Yes	No	_____

  

13.	Have you ever passed out during or after exercise?	Yes	No
14.	Have you ever been dizzy during or after exercise?	Yes	No
15.	Have you ever had chest pain during or after exercise?	Yes	No
16.	Have you ever had high blood pressure?	Yes	No
17.	Have you ever had high cholesterol?	Yes	No
18.	Do you have any skin problems (i.e., itching, rashes, acne)?	Yes	No
19.	Have you ever had heat illness or muscle cramps related to heat illness?	Yes	No
20.	Have you ever experienced any shortness of breath or unusual Fatigue associated with exercise?	Yes	No
	If yes, please explain_____		
21.	Do you have a history of asthma?	Yes	No
	If yes, do you have an inhaler?	Yes	No
22.	Do you use any special equipment (pads, braces, eye guards, etc.)?	Yes	No
23.	Do you have any problems with your eyes or vision?	Yes	No
24.	Do you wear contacts or glasses during competition?	Yes	No
25.	Are you missing one of the following: eye, kidney, lung, testicle, or any other organ?	Yes	No
26.	Have you ever had bleeding from rectum, blood in urine, or any unusual bleeding?	Yes	No
27.	Have you ever had any of the following medical problems:		
	Yes	No	Mononucleosis
	Yes	No	Anemia
	Yes	No	Ulcers
	Yes	No	Sickle cell
	Yes	No	Migraine Headaches
	Yes	No	Kidney Disease
	Yes	No	Hepatitis
	Yes	No	Chicken Pox
	Yes	No	Diabetes
	Yes	No	Rheumatic fever
	Yes	No	Hernia
	Yes	No	Marfan's Syndrome
	Yes	No	Depression
	Yes	No	Tuberculosis
	Yes	No	Crohn's Disease
	Others: _____		

Explain all "Yes" answers to questions 10-24:\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

28. When was the date of your last tetanus shot? \_\_\_\_\_
29. Have you ever been told you have a heart murmur? Yes No
30. Have you ever had racing of your heart or skipping heart beats? Yes No
31. Have you ever had an echocardiogram or EKG? Yes No  
If yes, when? \_\_\_\_\_
32. Have you ever been told you have any of the following? Yes No  
Heart disease  
Hypertrophic cardiomyopathy  
Long QT syndrome  
Dilated cardiomyopathy  
Any Arrhythmias

If yes, explain. \_\_\_\_\_

**Please sign:**

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

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Athlete's signature

Date signed

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Parent's signature if athlete is under 18

Date signed



## Florida Atlantic University Supplemental Medical History Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please fill out the following questions as truthfully as possible. The answers to these questions will be kept confidential. The information will be used by the attending physicians and athletic training staff as a supplement to your yearly physical examination.

1. How many meals do you eat each day? \_\_\_\_\_
2. Are there certain food groups you choose not to or refuse to eat (i.e. meat, dairy)?  
Yes No If yes, please give details \_\_\_\_\_
3. What was your highest and lowest weight over this past year? High Low
4. Are you happy with your present weight? Yes No
5. If no, what would you like your weight to be and why? \_\_\_\_\_  
\_\_\_\_\_
6. Are you currently restricting your food intake? Yes No
7. Have you ever been diagnosed as having an eating disorder? Yes No
8. Have you ever tried to control your weight by one or more of the following:  
Vomiting Using diuretics Laxatives Pills
9. Would you like to talk to someone about controlling your weight? Yes No

### *Mental Health Questions*

- |   |     |    |
|---|-----|----|
| 10. Do you find yourself feeling depressed?                 | Yes | No |
| 11. Do you have difficulty with anxiety?                    | Yes | No |
| 12. Do you have concerns about drug and alcohol abuse?      | Yes | No |
| 13. Have you noticed changes in eating and sleeping habit?  | Yes | No |
| 14. Do you have problems with anger?                        | Yes | No |
| 15. Have you ever thought or talked about suicide?          | Yes | No |
| 16. Does stress prevent you from reaching your goals?       | Yes | No |
| 17. Are having problems adjusting to your new surroundings? | Yes | No |
| 18. Are you struggling with guilt feelings?                 | Yes | No |
| 19. Are you a victim of abuse?                              | Yes | No |
| 20. Are you feeling lonely or homesick?                     | Yes | No |
| 21. I'm concerned about body image and weight?              | Yes | No |

**NOTE: ALL INFORMATION IS CONFIDENTIAL AND WILL ONLY BE USED BY THE SPORTS MEDICINE STAFF TO EVALUATE MENTAL HEALTH ISSUES.**

***(Male Only)***

22. Are you missing a testicle? Yes      No
23. Have you ever injured or had surgery on your testes? Yes      No  
If yes, please explain \_\_\_\_\_

***(Females Only)***

24. How often do you have a menstrual cycle? \_\_\_\_\_
25. How long does your menstrual cycles last? \_\_\_\_\_
26. How many menstrual cycles have you had in the last 12 months? \_\_\_\_\_
27. Have you ever had an appointment with a gynecologist? Yes      No
28. Have you ever had a pelvic exam? Yes      No
29. Would you like to discuss any gynecological problems you may have with a physician or staff member? Yes      No
30. Do you currently take birth control pills or hormones? Yes      No  
Name: \_\_\_\_\_
31. Have you ever been treated for toxic shock syndrome in the past year? Yes      No  
If yes, please give details. \_\_\_\_\_

# Florida Atlantic University Medical Insurance Information

NOTE: THIS FORM MUST BE FILLED OUT COMPLETELY

Athlete's Name \_\_\_\_\_ SS# \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_ Sex \_\_\_\_\_ Sport \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone Number \_\_\_\_\_ Country \_\_\_\_\_

Father/Guardian \_\_\_\_\_ Home Phone # \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer \_\_\_\_\_ Phone # \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Phone # \_\_\_\_\_  
Address for Claims \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Policy holder's SS# \_\_\_\_\_ Policy holder's date of birth \_\_\_\_\_  
Is your son/daughter covered under the above policy? Yes No

Type of Coverage: Does your insurance require:  
Health Maintenance Plan (HMO) Second opinion for surgery Yes No  
Preferred Provider (PPO) Pre-authorization Yes No  
Comprehensive Plan Referral for X-rays & MRI Yes No  
Other \_\_\_\_\_ Referral for specialist Yes No  
Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Mother/Guardian \_\_\_\_\_ Home Phone # \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer \_\_\_\_\_ Phone # \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Phone # \_\_\_\_\_  
Address for Claims \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Policy holder's SS# \_\_\_\_\_ Policy holder's date of birth \_\_\_\_\_  
Is your son/daughter covered under the above policy? Yes No

Type of Coverage: Does your insurance require:  
Health Maintenance Plan (HMO) Second opinion for surgery Yes No  
Preferred Provider (PPO) Pre-authorization Yes No  
Comprehensive Plan Referral for X-rays & MRI Yes No  
Other \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Phone# \_\_\_\_\_

I hereby authorize the physician(s) rendering service to submit a claim to my Health Insurance Company for all covered services rendered by the physician(s) and authorize and direct the Health Insurance Company to issue payment check(s) directly to the physician signing this report to furnish complete information to my Health Insurance Company regarding service rendered, and I hereby claim the amount of indemnity specified in my contract with my Health Insurance Company.

\_\_\_\_\_  
Signature of Policyholder(s)

\_\_\_\_\_  
Date



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### ASSUMPTION OF RISK

I, \_\_\_\_\_, verify that I have been informed that I may be injured while participating in intercollegiate athletic practice or competition. I understand that it is possible that I may sustain an injury that may result in permanent disability, paralysis, or possibly death. I understand that paralysis may include loss of movement, feeling, and use of my arms, legs, and trunk. I further understand that paralysis may involve complete loss of sexual function, and/or bowel and bladder control which would require the use of external aids, attached or inserted into my body for the collection and removal of body wastes.

I understand that paralysis and its effects could last my entire lifetime.

In addition, I understand that an injury to any of my body joints (Ankle, knee, hip, spine, shoulder, etc) may result in disfigurement, loss of movement, strength, or feeling which may last my entire lifetime.

I understand that it is my responsibility to adhere to all rules and regulations of my chosen sport. I understand that infraction of the rules may result in injury to my opponent or myself. I also understand that no modification of protective equipment or uniform should be made.

In addition, I understand that it is my responsibility to report faulty or poor fitting equipment immediately to the coach, equipment manager, or athletic trainer.

I understand that all injuries are to be reported to the athletic trainer. I understand that I am responsible for the follow-up care and treatment of my injuries under the supervision of the athletic training staff.

I accept these risks of participation in \_\_\_\_\_(sport) during the 20\_\_-20\_\_ seasons.

\_\_\_\_\_  
Athlete's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/guardian if under 18

\_\_\_\_\_  
Date



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### MEDICAL CONSENT

I, \_\_\_\_\_, hereby grant permission to the Florida Atlantic University team physicians and/or their consulting physicians to render to myself any treatment, medical, or surgical care that they deem reasonably necessary to my health or well-being. In the event that hospitalization is required, I give my permission for hospitalization at an accredited hospital.

I also hereby authorize the athletic trainers at Florida Atlantic University who are under the direct supervision of the team physicians, to render any preventative treatment, first aid, rehabilitation, or emergency treatment that they deem reasonably necessary to my health and well-being.

I also hereby consent to the affiliated hospital providing medical services to myself through a licensed physical therapist employed by the affiliated health provider

I also hereby authorized the athletic trainers at Florida Atlantic University to communicate and receive information from my insurance company facilities rendering medical treatment (i.e.; EOB, HCFA, & UB 92) in regards to claims and referrals related to athletic injuries.

\_\_\_\_\_  
Athlete's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian (if under 18)

\_\_\_\_\_  
Date



**Florida Atlantic University  
Assignment of Benefits  
For Prescription Insurance Release**

I, \_\_\_\_\_, authorize my athletic trainer under supervision and protocol of the team physician, to act as my agent to receive, procure, store, and issue any medications, which are prescribed for me. I will take the necessary precautions to keep the non-child safety resistant blister packs out of the reach of children.

I further authorize Homelink National Pharmacy to bill and receive funds from my carrier on behalf of my team physician and my university as a billing service.

My signature below authorizes the above statements and assignments of benefits.

_____ Name	_____ Signature	_____ Date
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**IF ATHLETE IS UNDER THE AGE OF 18, PARENT/GUARDIAN MUST SIGN BELOW:**

_____ Name of Parent/Guardian	_____ Signature	_____ Date
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