

UNIVERSITY OF RICHMOND SPORTS MEDICINE ANNUAL ATHLETIC HEALTH HISTORY

NAME: _____ DATE OF BIRTH: _____
 SPORT: _____ SEX: *M F* YEAR IN SCHOOL: 1st 2nd 3rd 4th 5th
 SS#: _____ - _____ - _____ STUDENT ID# _____
 HOME ADDRESS: _____
 HOME TELEPHONE: _____ CELL PHONE : _____

*First year participants must also submit a copy of the University of Richmond Student Health Center Health History Record (Physical).

MEDICAL HISTORY

DO YOU HAVE/ HAVE YOU EVER HAD/ EVER BEEN TESTED FOR:		Explain any "YES" answers:
ASTHMA / BREATHING DIFFICULTY / COUGH WITH EXERCISE?	NO YES	
ANY ALLERGIC REACTIONS TO MEDICATION(S) OR INSECTS?	NO YES	
ANY TYPE OF EATING DISORDER: ANOREXIA / BULIMIA?	NO YES	
RHEUMATIC FEVER / SCARLET FEVER?	NO YES	
DIABETES?	NO YES	
EPILEPSY / CONVULSIONS / SEIZURES?	NO YES	
ANY BLEEDING PROBLEMS?	NO YES	
SICKLE CELL ANEMIA / SICKLE CELL TRAIT?	NO YES	
AN IMMUNE SYSTEM DISEASE?	NO YES	
A HERNIA?	NO YES	
KIDNEY DISEASE?	NO YES	
A STOMACH DISORDER / APPENDICITIS?	NO YES	
A HEART MURMUR / HEART PROBLEM?	NO YES	
HEAT-RELATED ILLNESS / SEVERE CRAMPS / PASSING OUT?	NO YES	
RECURRENT HEADACHES?	NO YES	
MONONUCLEOSIS?	NO YES	
ABDOMINAL PAIN / NAUSEA?	NO YES	
CHEST PAIN WITH EXERCISE?	NO YES	
LIGHTHEADEDNESS / DIZZINESS / FAINTING WITH EXERCISE?	NO YES	
RACING OF YOUR HEART / SKIPPED BEATS?	NO YES	
PNEUMONIA?	NO YES	
ALL PAIRED ORGANS? (eye, lung, kidney, ovary, testicle)	NO YES	
HAVE YOU BEEN HOSPITALIZED?	NO YES	
ANY SCREW, PIN, OR PLATE IN YOUR BODY?	NO YES	
ANY TYPE OF SURGERY?	NO YES	
ARE YOU TAKING ANY MEDICATIONS?	NO YES	
HAVE YOU BEEN DIAGNOSED BY A PHYSICIAN FOR ADD/ADHD	NO YES	
IS ANY DOCTOR PRESENTLY TREATING YOU FOR ANY DISORDER?	NO YES	

VISION HISTORY

DO YOU WEAR GLASSES OR CONTACTS DURING SPORTS PARTICIPATION?	NO YES	If "yes", which:
*** If so, what is your uncorrected vision? Right 20/_____ Left 20/_____		Please provide eye wear/contact prescription.
DO YOU HAVE ANY TYPE OF EYE TROUBLE?	NO YES	If so, what?

DENTAL HISTORY

DO YOU HAVE ANY CHIPPED, LOOSE, OR MISSING TEETH?	NO YES	If yes, explain:
DO YOU WEAR A DENTAL APPLIANCE?	NO YES	
DO YOU HAVE ANY TYPE OF DENTAL TROUBLE?	NO YES	

FAMILY HISTORY

HAVE ANY OF THE FOLLOWING CONDITIONS BEEN PRESENT IN YOUR FAMILY?		If yes, in whom? (Explain)
HEART CONDITIONS?	NO YES	
HIGH BLOOD PRESSURE?	NO YES	
SICKLE CELL ANEMIA OR TRAIT?	NO YES	
DIED WHILE EXERCISING?	NO YES	
MARFAN'S SYNDROME	NO YES	

INJURY HISTORY

HAVE YOU HAD AN INJURY OF:		SIDE	DATE:	Current Problem?	Describe:
HEAD (concussion - "knocked out", surgery, hospitalization, other)	NO YES	Left Right		N Y	
FACE (fracture, eye injury, ear problem, broken nose - deviated septum, other)	NO YES	Left Right		N Y	
NECK (strain, fracture, "stinger - burner", surgery, other)	NO YES	Left Right		N Y	
SHOULDER (dislocation, separation, rotator cuff injury, tendinitis, surgery, other)	NO YES	Left Right		N Y	
ARM / ELBOW (joint sprain, muscle strain, fracture, tendinitis, dislocation, surgery, other)	NO YES	Left Right		N Y	
WRIST / HAND (sprain, fracture, tendinitis, surgery, other)	NO YES	Left Right		N Y	
FINGER(S) (sprain, fracture, surgery, other)	NO YES	Left Right		N Y	
CHEST (lung injury, heart injury, other)	NO YES	Left Right		N Y	
ABDOMEN (kidney injury, spleen injury, liver injury, other)	NO YES	Left Right		N Y	
GENITALIA (groin, testicle - ovary, other)	NO YES	Left Right		N Y	
BACK (strain, chronic pain, slipped disc, surgery, other)	NO YES	Left Right		N Y	
HIP / THIGH (fracture, muscle strain, calcium deposit, surgery, other)	NO YES	Left Right		N Y	
KNEE (sprain, cartilage, pain, bursitis, tendinitis, surgery, other)	NO YES	Left Right		N Y	
LOWER LEG (sprain, fracture, surgery, other)	NO YES	Left Right		N Y	
ANKLE (sprain, fracture, tendinitis, other)	NO YES	Left Right		N Y	
FOOT (sprain, fracture, plantar fasciitis - heel spur, surgery, other)	NO YES	Left Right		N Y	
TOE(S) (fracture, surgery, other)	NO YES	Left Right		N Y	

GENERAL INFORMATION

Have you been wearing any type of brace, support, tape, or other special padding for play?	NO YES	If yes, explain:
Have you had an illness or injury in the last 12 months that has not been listed above?	NO YES	
Have you used / Are you using any type of performance-enhancing substances or drugs?	NO YES	
Do you know of any health reason why you should not participate or have limited participation with the UR intercollegiate athletic program at this time?	NO YES	

THE UNDERSIGNED ATHLETE:

Understands that he/she must refrain from practice or play while ill or injured, whether or not receiving medical treatment, and during medical treatment until he/she is discharged from treatment or is given permission by the University of Richmond Team Physician to restart participation despite continuing treatment.

- Understands that having passed the physical examination does not necessarily mean that he/she is physically qualified to engage in athletics, but only that the evaluator did not find a medical reason to disqualify him/her at the time of said evaluation.
- If answered yes to any of the above questions, I will be able to provide necessary documentation (Doctor's dictations, notes, diagnostic testing, etc.) on the date of my pre-participation physical exam.
- Certifies that the answers to the above questions are correct and true.

PARENT'S SIGNATURE _____ DATE _____

PRINT ATHLETE'S NAME _____

SOCIAL SECURITY NO. _____ DATE OF BIRTH _____

ATHLETE'S SIGNATURE _____ DATE _____