



## Student Athlete Medical History

Name: \_\_\_\_\_ 1000#: \_\_\_\_\_ Sport: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_\_\_

Grade (circle one): FR SO JR SR 5th

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # \_\_\_\_\_ - \_\_\_\_\_

### I. General Health Questions

Have you been under the care of a physician, any time in the PAST 3 YEARS? YES NO  
If yes, please explain:

Have you ever had any SURGERY (including pin, plate, fracture, etc.)? YES NO  
If yes, please explain (date, site of injury, type of surgery) Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_  
Injury/Surgery:

Have you ever had any MAJOR injuries resulting from sports participation? YES NO  
(Fractures, Dislocation, Ligament rupture, etc) If yes, please explain:

#### Eyes

Do you wear glasses? YES NO

Do you wear contact lenses? YES NO

When was your last eye exam? \_\_\_\_\_

Have you ever suffered an injury to your eye(s)? YES NO

If YES, please explain and provide dates.

\_\_\_\_\_

Do you regularly suffer from blurred vision, double vision, tunnel vision, and/or other abnormal vision? YES NO

If YES, please explain.

\_\_\_\_\_

#### Dental

When was your last dental exam? \_\_\_\_\_

Were there any significant findings from your last dental exam? YES NO

Have you ever suffered an injury to your mouth, jaw, tooth, or teeth? YES NO

If YES, please explain and provide dates.

\_\_\_\_\_

\_\_\_\_\_

Do you wear a mouthguard while playing sports? YES NO

**Cardiovascular/Heart**

Have you ever experienced any of the following during or after exercise, a practice, or a game?:

Chest pain or pressure YES NO

Dizziness or light headedness YES NO

Fainting or passing out YES NO

Racing heart YES NO

Skipping or irregular heart beats YES NO

Do you fatigue or get tired quicker than your teammates and friends during exercise or practice? YES NO

Have you ever been told you have a heart murmur? YES NO

Has a family member or relative died of heart problems or sudden death before the age of 50? YES NO

Has a physician ever denied or restricted you from playing sports due to heart or cardiovascular problem or family history? YES NO

Have you ever been examined by a cardiologist? YES NO

Have you ever had an electrocardiogram (EKG) and/or echocardiogram (ECHO)? YES NO

Does anyone in your family have high blood pressure? YES NO

Does anyone in your family have high blood cholesterol? YES NO

Have you ever been told you have/had high blood pressure? YES NO

Have you ever been told you have/had high cholesterol? YES NO

Have you or any family member ever been diagnosed with enlarged heart, hypertrophic cardiomyopathy, Long QT syndrome, Marfan's syndrome, or abnormal heart rhythm? YES NO

If you answered **YES** to any of the above questions, please explain

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**Head Injuries/Concussion**

Have you ever suffered a head injury/concussion (no matter how minor)? YES NO

Have you ever been evaluated by a doctor for a head injury/concussion? YES NO

Have you ever had any of the following tests performed on your head/brain?:

XRAY YES NO

MRI YES NO

CT Scan YES NO

Neuropsychological tests YES NO

Other \_\_\_\_\_ YES NO

Have you ever been hospitalized, knocked out, become unconscious, and/or lost your memory due to getting hit in the head/concussion/head injury? YES NO

Have you been advised not to participate in athletic activities due to a head injury/concussion? YES NO

If yes, how long did you refrain from activity?

Have you experienced headaches for more than three months? YES NO

If you answered **YES** to any of the above, please explain and provide dates

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Do you suffer from headaches? YES NO

If yes, when? (circle one)

EVERYDAY    1-2 TIMES A WEEK    1-2 TIMES A MONTH    OTHER \_\_\_\_\_

Do you suffer from migraines? YES NO

How often? \_\_\_\_\_

Migraine Medication? (please list) \_\_\_\_\_

**Asthma**

Have you ever been diagnosed with asthma and/or exercise induced asthma? YES NO  
Are you presently taking or have taken in the past any asthma medications? YES NO  
Have you ever been hospitalized as a result of asthma and/or exercised induced asthma? YES NO  
Have you ever been advised not to participate in athletic activities due to asthma? YES NO  
Does anyone in your family suffer from asthma? YES NO  
Do you currently have trouble breathing during exercise or practice? YES NO  
If you answered **YES** to any of the above, please explain and list all asthma medications.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ASTHMA SUFFERERS ONLY:**

How many times do you use your rescue inhaler during an average week? \_\_\_\_\_  
How many asthma attacks have you had in the last month? \_\_\_\_\_

**Allergies**

Do you have any allergies to medications, foods, insect bites, and /or bee stings ? YES NO  
If you answered **YES** to any of the above, please list all allergies.

\_\_\_\_\_  
\_\_\_\_\_

Have you been diagnosed with seasonal allergies? YES NO  
Are you currently taking/have you previously taken allergy medication? YES NO  
If you answered **YES**, please list all allergy medication you are currently taken or have taken.

\_\_\_\_\_

**Ear/Nose/Throat**

Do you have frequent ear infections? YES NO  
Do you have difficulty hearing? YES NO  
Do you have ringing in your ears? YES NO  
Do you have frequent nosebleeds? YES NO  
Have you ever fractured your nose? YES NO

**Heat Related Injury and Illness**

Have you ever suffered from heat cramps, heat exhaustion, and/or heat stroke? YES NO  
Have you ever been hospitalized for a heat related injury or illness? YES NO  
If you answered **YES** to any of the above, please explain and provide dates.

\_\_\_\_\_  
\_\_\_\_\_

**Communicable Diseases**

Have you ever been diagnosed with a communicable disease (MRSA/Staph infection, Sexually Transmitted Disease, HIV, Hepatitis, Herpes, Syphilis, Tuberculosis, meningitis, etc.)? YES NO  
If **YES**, please list and provide dates.

\_\_\_\_\_  
\_\_\_\_\_

**MEDICATION**

Please list **ALL** prescription and over-the-counter medication you are currently taking . Please indicate the reason for the medication, as well as the dates.

**MEDICATION PURPOSE DOSAGE DATES**

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Have you ever been diagnosed with ADD (Attention Deficit Disorder) or ADHD (Attention Deficit and Hyperactivity Disorder)? YES NO

Are you currently taking medication for ADD (Attention Deficit Disorder) or ADHD (Attention Deficit and Hyperactivity Disorder)? YES NO

If yes, please list the medication \_\_\_\_\_

**Women's Health** (females only)

Date of your last pap smear? \_\_\_\_\_

Are you currently taking any form of birth control? (pill, patch, NuvaRing, etc.) YES NO

Other than routine exams, are you currently under the care of an OB/GYN for an ongoing problem? YES NO

If **YES**, please explain:

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How many periods have you had in the last 12 months? \_\_\_\_\_

**Additional Health Concerns**

Have you had any injury or illness other than those previously noted? YES NO

Do you have any ongoing or chronic illnesses? YES NO

Have you ever been hospitalized overnight? YES NO

Has a physician ever restricted you from athletic activities, practices, or other exercise for any reason? YES NO

Are you currently under a physician's care for any medical condition(s)? YES NO

Are you happy with your weight? YES NO

Are you currently trying to gain or lose weight? YES NO

Have you experienced any recent weight loss or weight gain in the last 6 months? YES NO

Do you have any dietary restrictions (vegetarian-all types, gluten free, etc.)? YES NO

Have you ever been diagnosed with an eating disorder? YES NO

Have you had a viral infection (mononucleosis, myocarditis, etc.)? YES NO

Have you ever been told you are hypoglycemic, hyperglycemic, or diabetic? YES NO

Have you had a seizure, convulsions, or been diagnosed with epilepsy? YES NO

Have you suffered a traumatic injury or unexpected illness that was not sports-related, but required immediate medical attention? YES NO

Have you ever been restricted from playing sports for a month or more due to a non-orthopaedic injury or illness? YES NO

Were you born without or are you missing a kidney, eye, testicle, or any other organ? YES NO

Do you currently have any health concerns you would like to discuss with a physician? YES NO

Please explain any **YES** answers here:

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**Family History**

CIRCLE the following disease, if present, in any blood relation family member. If YES is circled, state whom was affected. **RELATION**

YES NO	1. CANCER	_____
YES NO	2. DIABETES	_____
YES NO	3. HIGH BLOOD PRESSURE	_____
YES NO	4. HEART DISEASE	_____
YES NO	5. BLOOD DISEASE	_____
YES NO	6. SICKLE CELL	_____

YES NO

7. SUDDEN DEATH, unexplained

\_\_\_\_\_

**Orthopaedic History**

**Cervical Spine/Neck**

Have you ever suffered an injury to your cervical spine/neck?	YES NO
Have you ever had a “burner”, “stinger”, or other brachial plexus injury?	YES NO
Have you ever experienced numbness and/or tingling in your arms, hands, and/or fingers?	YES NO
Have you ever been advised not to participate in sports due to a c-spine/neck injury?	YES NO

If **yes** to any of the above, please explain and provide dates.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Shoulder/Arm- Have you suffered from:**

YES NO	FRACTURES	R/L
YES NO	DISLOCATIONS	R/L
YES NO	Have you ever had any diagnostic tests performed on your shoulder?	R/L
	If yes, please circle all the apply: X-RAY MRI CT SCAN BONE SCAN OTHER _____	
YES NO	Have you ever had surgery and/or injection of any kind to your shoulder?	R/L
	Have you ever been advised not to participate in sports due to a shoulder/upper arm injury?	YES NO

If **yes** to any of the above, please explain and provide dates.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Elbow/Forearm- Have you suffered from:**

YES NO	FRACTURES	R/L
YES NO	DISLOCATIONS	R/L
YES NO	HYPEREXTENSIONS	R/L
YES NO	SPRAINS	R/L
YES NO	OTHER INJURY: _____	R/L

**Wrist/Hand/Fingers- Have you suffered from:**

YES NO	FRACTURES	R/L
YES NO	DISLOCATIONS	R/L
YES NO	SPRAINS	R/L
YES NO	OTHER INJURY: _____	R/L

**Hip/Groin**

Have you ever suffered an injury to your hip/groin?	YES NO
Have you ever been advised not to participate in sports due to a hip/groin injury?	YES NO

If **yes** to any of the above, please explain and provide dates.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Foot/Toes**

Have you suffered an injury to your foot/toes? YES NO  
Have you ever had surgery and/or an injection of any kind to your foot/toes? YES NO  
Have you ever been advised not to participate in sports due to a foot/toe injury? YES NO  
Do you currently wear orthotics? YES NO

If **yes** to any of the above, please explain and provide dates.

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**Knee/Patella- Have you suffered from:**

YES NO Have you ever suffered an injury to your knee/patella? R/L  
YES NO Have you ever had any diagnostic tests performed on your thigh/hamstrings/quadriceps? R/L  
If yes, please circle all the apply: X-RAY MRI CT SCAN BONE SCAN OTHER \_\_\_\_\_  
YES NO Have you ever had surgery and/or injection of any kind to your knee/patella? R/L  
YES NO Have you ever been advised not to participate in sports due to a knee/patella injury?  
YES NO Do you wear a knee brace?

If **yes** to any of the above, please explain and provide dates.

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**Ankle/Lower Leg- Have you suffered from:**

YES NO FRACTURES R/L  
YES NO DISLOCATIONS R/L  
YES NO SPRAINS R/L  
YES NO OTHER INJURY: \_\_\_\_\_ R/L

Have you ever been advised not to participate in sports due to an ankle/lower leg injury? YES NO

Do you presently tape your ankles regularly? YES NO

Do you presently wear ankle braces? YES NO

If **yes** to any of the above, please explain and provide dates.

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*To be completed by student-athlete or parent/guardian if under the age of 18.*

I have completed all of the University of Texas at Arlington Student Athlete Medical History form accurately. I have included any medical records pertaining to any significant injuries or illnesses I have experienced. I understand that the UTA Sports Medicine Staff may ask for additional medical records and/or information pertaining to insurance or medical history and that failure to provide requested documents may delay participation in intercollegiate athletics.

\_\_\_\_\_  
Student-Athlete Signature

\_\_\_\_\_  
DATE

SSN: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature (If athlete is a minor)

\_\_\_\_\_  
DATE