THE UNIVERSITY OF TEXAS AT ARLINGTON
MEDICAL INFORMATION

Date: _______________

The completion of this form is of great importance for emergency situations.
Please make sure that all questions have been answered.

NAME: ____ SPORT: ______________________
Last First MI

CAMPUS ADDRESS: ____

SINGLE/MARRIED: SPOUSE'S NAME ________________________ SSN#: _______-______-______

CAMPUS PHONE: ( ) - CELL PHONE: ( ) -

DATE OF BIRTH: _______________________ AGE: _______

HIGH SCHOOL: ____

HEAD COACH: ________________________________ TRAINER: ____________________________

COLLEGE/JC: ____

HEAD COACH: ________________________________ TRAINER: ____________________________

FATHER: NAME: ____

ADDRESS: ____

CITY: _____________________________ STATE: _______ ZIP: ___________________

PHONE: (HOME) ( ) - (CELL) ( ) -

MOTHER: NAME: ____

ADDRESS: ____

CITY: _____________________________ STATE: _______ ZIP: ___________________

PHONE: (HOME) ( ) - (CELL) ( ) -

IN CASE OF EMERGENCY PLEASE NOTIFY:

NAME: ____

ADDRESS: ____

PHONE: ( ) - RELATIONSHIP: ________________________

MEDICAL INFORMATION

FAMILY PHYSICIAL: ____

ADDRESS: ____

CITY: ____________________ STATE: ______ ZIP: ______________

PHONE: (   )   -   BLOOD TYPE: __________________

FAMILY HISTORY OF: (Please circle and give relation)

TB __________ Diabetes ____________ Cancer ______________

High Blood Pressure ________________ Heart Disease _______________

MEDICAL HISTORY

RECORD OF ILLNESS (Check those you have had; star those you have had in the past 5 years)

___ Allergies
___ Appendicitis/Appendectomy
___Arthritis
___ Asthma
___ Bronchitis
___Chickenpox
___ Convulsions/fits
___ Diabetes
___Diphtheria
___ Epilepsy
___ Frequent Colds
___ Bone & Joint Disease

___ Skin Disease
___ Hay Fever
___ Heart Disease/Trouble
___ Heat Exhaustion/Stoke
___ Hepatitis
___ Hernia or Rupture
___ Hives
___ Influenza
___ Kidney Disease
___ Bladder Problems
___ Malaria
___ Measles

___ Mononucleosis
___ Mumps
___ Poliomyelitis
___ Pneumonia
___ Rheumatic Fever
___ Scarlet Fever
___ Smallpox
___ Tonsillitis/Tonsillectomy
___ Tuberculosis
___ Ulcer
___ Whooping Cough

RECORD OF SYMPTOMS (Check those which you have had; star those you have now)

___ Aching Eyes
___ Sties
___ Blurred Vision
___ Inflamed Eyelids
___ Ringing in Ears
___ Difficulty Hearing
___ Discharging Ear
___ Ear Inflections
___ Nasal Discharge
___ Sinus Infection
___ Nosebleed
___ Sore Throat
___ Cough (Prolonged)
___ Hoarseness (Laryngitis)
___ Headaches
___ Blackouts

___ Tumor, Growth, Cyst
___ Blood In Urine
___ Sugar In Urine
___ Gallbladder Trouble
___ Abdominal Pains
___ Diarrhea
___ Jaundice
___ Vomiting
___ Constipation
___ Indigestion
___ Boils
___ Acne
___ Eczema
___ Hemorrhoids
___ Painful Urination
___ Frequent Urination

___ Swelling of Ankles
___ Fluid Retention
___ Fainting Spells – Dizzy
___ Palpitation/Pounding of Heart
___ Toothaches
___ Swollen or Painful Joints
___ Backache
___ Leg Pains – Cramps
___ Shortness of Breath
___ Chest Pains
___ High Blood Pressure
___ Heart Murmur
___ Insomnia
___ Motion Sickness
___ Recent Gain or Loss of Weight

Yes	No	
☐	☐	1. Have you had a medical illness or injury since you last check up or sports physical?
☐	☐	2. Have you ever been hospitalized overnight?
☐	☐	3. Have you ever had surgery?
☐	☐	4. Have you ever taken any supplements or vitamins to help gain or lose weight or improve performance?
☐	☐	5. Have you ever had a rash or hives develop during or after exercise?
☐	☐	6. Do you get tired more quickly than your friends do during exercise?
☐	☐	7. Has a physician ever denied/restricted your participation in sports for a heart problems?
☐	☐	8. Have you ever had numbness or tingling in your arms, hands, legs, or feet?
☐	☐	9. Have you ever had a stinger, burner, or pinched nerve?
☐	☐	10. Do you want to weigh more or less than you do right now?
☐	☐	11. Do you lose weight regularly to meet weight requirements for your sport?
☐	☐	12. Do you feel stressed out?

FEMALES ONLY
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? __________________
Are you taking birth control pills? ___________________

EYES
Do you wear glasses? _______________________ Do you wear contact lenses? _______________________
Do you wear glass or contact lenses when you compete in athletics? _________________________________
Do you have a spare set of contact lenses? ___________________

TEETH
Date of last dental examination or treatment: ________________________
Dentist performing last examination or treatment: ____
Address: ____
Do you have false teeth or plates? ____________ Where? ____
Did you wear a mouthpiece in High School? __________ Would you like one made? _________________

TONSILS
Present _______ Removed ___________ Do you have frequent sore throats? _________________________

ALLERGIES
Do you have any allergies? ___________ If yes, please list (foods, medications, insects, etc.): __________
____

MEDICATIONS
Are you currently taking any medications? ____________ If yes, please list: __________________________
____
If you have asthma, do you have an inhaler and how often do you use it?______________________
Have you required any special adhesive taping, wrapping or protective services (braces) for participation in athletic competition, if so please describe? ____
____

PREVIOUS SPORTS INJURIES RESULTING IN LOSS OF TIME FROM PRACTICE OR COMPETITION:

List all injuries that resulted in your missing at least one game or four consecutive practices (sprains, strains, fractures/breaks, dislocations, concussions, cartilage injuries of the knee, etc.) and list the approximate date or year of all injuries. Also, please list the name of the attending physician.

FACE/HEAD: (include all injuries involving any period of unconsciousness or loss of memory)

NECK/BACK:

SHOULDER: (acromioclavicular separation, shoulder dislocation)

CHEST/ABDOMEN:

ELBOW, WRIST, HAND, FINGERS:

HIP, GROIN, THIGH, CALF, SHIN:

KNEE: (including cartilage injuries, ligament injuries, Osgood Schlatters disease, kneecap injuries, bursitis, etc.)

ANKLE/FOOT: (heel, foot, arch, toes)

PREVIOUS FRACTURES (if not listed under one of the above categories – list all and specify)

LIST ALL OTHER SERIOUS INJURIES NOT RESULTING FROM SPORTS