



Wright State University Parent Information

Father/Guardian: _____

Date of Birth: _____

Social Security: _____

*only needed if used for insurance identification purposes

Address: _____
Street

City State Zip Code Country

Phone Number: _____

Mother/Guardian: _____

Date of Birth: _____

Social Security: _____

*only needed if used for insurance identification purposes

Address: _____
Street

Country City State Zip Code

Phone Number: _____

E-mail Address: _____



Wright State University

Personal Information

Name: _____

Sport: _____

Sex: _____

Date of Birth: _____

UID: _____

Permanent Address: _____
Street

City

State

Zip Code

School Address: _____
Street

City

State

Zip Code

Home Phone: _____

School Phone: _____

Cell Phone: _____

Emergency Contact: _____

Relationship: _____

Phone Number: _____

Alternate Number: _____

Wright State University Medical History Form

OFFICE USE ONLY	
Test	Initial
Med. Hist	
Lab	
Xrays	
EKG	

Sport:		Date entering WSU:	
Last Name:		First Name:	
Middle Name :		Nickname:	
SS#: - -	Date of Birth: / /		Age:
Sex :	Marital Status :	Place of Birth :	

General Medical Concerns

Family History:

Has any blood relative ever had the following illnesses:	Please check one		WHO?
	YES	NO	
Sudden Death (Before age 55)			
Prolonged QT Interval			
Blood Disease (Sickle Cell, Leukemia)			
Diabetes			
Epilepsy			
Gout			
Heart Disease			
Hemophilia			
High Blood Pressure			
Depression, Anxiety or Suicide			
Marfan's Syndrome			
Stroke			
Tuberculosis			
Drug and/or Alcohol dependency			

IMMUNIZATION RECORD COMPLETED

	YES	NO	Date of Injection		
Tetanus/Diphtheria					
Measles, Mumps and Rubella (MMR)			1)	2)	
Measles, and Rubella (MR)			1)	2)	
Influenza					
Hepatitis B			1)	2)	3)

GENERAL MEDICAL HEALTH HISTORY 1

Have you EVER had the following conditions?								
	YES	NO		YES	NO		YES	NO
Elevated Cholesterol			Skin Disease			Arthritis (Rhematoid or Degenerative)		
High Blood Pressure			Diabetes			Other Rheumatologic Disorders (Lupus, Fibromyalgia, other)		
Rheumatic Fever			Sickle Cell Anemia/ Carrier (Trait)			Attention Deficit Disorder		
Rheumatic Heart Disease			Anemia			Learning Disabilities		
Pericarditis			Abnormal Bruising					
Any Heart Disease?			Abnormal Bleeding Tendency					
Tumor, Growth, Cyst, Cancer			Blood Disease					
Any Ruptured organs?			Blood Clots or Phlebitis					
Hepatitis			Kidney Disease					
Jaundice			Kidney Stones					
Gout			Kidney Injury					
Pneumonia			Blood in Urine					
Polio			Frequent Urinary Infections					
Bronchitis			Hearing Defect / Loss					
Frequent Respiratory Infections			Ear Infection					
Tuberculosis			Muscular Disease					
Malaria			Birth Defects					
Mumps			Appendicitis					
Mononucleosis			Stomach Ulcer (peptic)					
Red Measles (Rubeola)			Gastrointestinal Bleeding					
Rubella			Constipation					
Chicken Pox			Hemorrhoids					
Asthma			Hernia					
Exercise Induced Asthma			Herpes (Oral)					
Sinus Infection			Herpes (Genital)					
Nasal Polyps			Sexually Transmitted Diseases					
Nose Fracture			Car or Air Sickness					
Amnesia			Eating Disorder					
Meningitis			Panic Attacks					
Migraine Headaches			Drug Dependency					
Seizure Disorder			Joint Inflammation					
Goiter, Thyroid Disease								
Marfan's Syndrome								

COMMENTS:

GENERAL MEDICAL HEALTH HISTORY 2

Do you CURRENTLY have any of the following SYMPTOMS or PROBLEMS :					
	YES	NO		YES	NO
Frequent Headaches			Abdominal Pain		
Visual Changes			Muscle Cramps		
Ringing In Ears			Frequent Nausea		
Sore Throat			Frequent Vomiting		
Sinus Congestion			Frequent Diarrhea		
Breathing Difficulty			Rectal Bleeding		
Recurring Cough			Unusual Fatigue		
Chest Pain			Trouble Sleeping		

INTERNAL

Were you born with a complete and functional set of paired organs? (eyes, ears, kidneys, ovaries/testicles, lungs):

(Check) YES _____ or NO _____; If no, which organs were involved?: _____

Have you ever had surgery to repair or remove any organ? (hernia, tonsils, appendix, spleen, etc): YES NO

1. If yes ,which organ?: _____ (Check) Repaired _____ Removed _____ Date _____
Physician _____ Address _____

2. If yes ,which organ?: _____ (Check) Repaired _____ Removed _____ Date _____
Physician _____ Address _____

CARDIAC	YES	NO
Have you ever felt dizzy, light-headed or passed out during or after exercise?		
Have you ever passed out without exercise?		
Do you tire more quickly than your friends during exercise?		
Have you ever had chest pain while exercising?		
Have you ever had irregular heart beats or heart racing?		
Have you ever been told you have a heart murmur?		
Have you ever been seen by a heart specialist?		
If yes? Who: _____ Date: _____		
Have you ever had an echocardiogram?		
Have you ever had an Exercise Stress Test (Treadmill)?		

VISION	YES	NO
Have you ever been to an eye doctor?		
Do you wear glasses now?		
If yes, Reading only:		
Distance only:		
All the time:		
Do you wear contact lenses?		
If yes, Soft lenses:		
Hard lenses:		
Do you have second pair?		
Do you wear contact lenses/glasses to participate?		
Have you ever had an eye injury?		
Is your color vision normal?		
Have you ever worn a false eye?		

Date of last visit: _____

Physician's name: _____

Glasses Prescription:

R _____

L _____

Contacts Prescription:

R _____

L _____

Date of eye

injury: _____

Explain: _____

GENERAL MEDICAL HEALTH HISTORY 3

DENTAL

Do you now have or experienced any of the following?	YES	NO	COMMENTS
Do you have a bridge or false teeth?			
Have you ever fractured a tooth?			
Do you wear a mouth protector?			
Do you wear orthodontic appliances?			
Have you ever had a tooth knocked out?			

HEAT

Have you ever experienced any of the following?:	YES	NO
Trouble with dehydration (Excessive loss of salt and water)		
Heat Stroke		
Heat Cramps (Due to fluid loss because of excessive heat)		
Heat Intolerance		

ALLERGIES

Are you allergic to...?	YES	NO		YES	NO
Aspirin			Insect Bites/ Stings		
Codeine			Tetanus Antitoxin or Serums		
Cortisone			Nail Polish or Cosmetics		
Sulfa			Adhesive Tape		
Anti-inflammatories			Any Foods:		
Penicillin			Any other drug:		
Hay Fever			Other:		

DRUG, FOOD SUPPLEMENTS AND MISCELLANEOUS AGENTS

Check the appropriate space according to YOUR use of the following items:

	Never	Rarely	Occasionally	Frequently
Vitamins				
Diet Pills				
Sleeping Pills				
Laxatives				
Alcoholic Beverages				
Antihistamines				
Anti-inflammatories				
Caffeine				
Tobacco				
Creatine				
Weight Gain Supplements				
Other Supplements?				
Other				

List all medications that you currently take: _____

MISCELLANEOUS- Have you ever...?

	YES	NO		YES	NO
Worn hearing aids			Do you have any pins, staples, or wires in any part of your body		
Stuttered or stammered					
Bled excessively after injury			Had any illnesses other than those already noted		
Been advised to have any operations					
Ever coughed up blood			Have you ever missed a game because of illness		
Would you like to see a nutritionist					
Would you like to see a counselor					

GENERAL MEDICAL HEALTH HISTORY 4

SUPPLEMENTAL HEALTH HISTORY QUESTIONNAIRE FOR THE FEMALE ATHLETE

Directions:

Please answer the following to the best of your ability.

1.	How old were you when you had your first menstrual period?	
2.	How often do you have a period?	
3.	How long do your periods last?	
4.	How many periods have you had in the last 12 months?	
5.	When was your last period?	
6.	Do you ever have trouble with heavy bleeding?	
7.	Do you have any questions about tampon use?	
8.	Do you ever experience cramps during your period?	
9.	Do you take birth control pills or hormones?	
10.	Do you have any unusual discharge from your vagina?	
11.	When was your last pelvic exam?	
12.	Have you ever had an abnormal PAP smear?	
13.	How many urinary tract infections (bladder or kidney) have you had?	
14.	Have you ever been treated for anemia?	
15.	How many meals do you eat each day? <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>How many snacks?</td></tr></table>	How many snacks?
How many snacks?		
16.	What have you eaten in the last 24 hours? 	
17.	Are there certain food groups you refuse to eat (i.e. meats, breads, fish, poultry, vegetables)? Please explain: 	
18.	Have ever been on a diet?	
19.	What is your present weight?	
20.	Are you happy with your present weight?	
21.	If not happy with weight what would you like to weigh?	
22.	Have you ever tried to control your weight by vomiting?	
23.	Have you ever been diagnosed as having an eating disorder?	
24.	Do you have any questions about healthy ways to control weight? 	

ORTHOPEDIC HISTORY QUESTIONNAIRE 1

Please place a check in either the **YES** or **NO** box, if yes please explain

If you have any questions or uncertainties, please ask any medical personnel for assistance.

HAVE YOU EVER INJURED OR CONSULTED A DOCTOR ABOUT ANY INJURY TO THE FOLLOWING BODY PARTS (SEE EACH SECTION):

HEAD	YES	NO	DATE	COMMENTS
Unconscious				
Dazed/ Dizzy				
Knocked Out				
Concussions				
Headaches				
Injections				
Pains				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practices				
Missed Games				
Other				

NECK	YES	NO	DATE	COMMENTS
Sprain / strain				
Stretches				
Pinches				
Disk Injury				
Dislocations				
Burners / Stingers				
Injections				
Pains				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

Football Only – Do you wear a neck roll? YES NO If yes do you know the type or brand?
--

CHEST WALL	YES	NO	DATE	COMMENTS
Fractured Collar Bone				
Fractured Ribs				
Sterno-Clavicular Joint Separation				
Bursitis				
Pains				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

ORTHOPEDIC HISTORY QUESTIONNAIRE 2

LOWER BACK	YES	NO	DATE	COMMENTS
Sprain / strain				
Nerve Pinches				
Disk Injury				
Referred Pain				
Numbness in leg				
Weakness in leg				
Pain down leg				
Bruise				
Injections				
Pains				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

SHOULDERS	YES	NO	DATE	COMMENTS
Sprain / Strain				
A-C Separations				
Dislocations				
Partial Dislocation				
Shoulder slips out of place				
Tendinitis				
Bursitis				
Injections				
Pain w/ Overhead Activities				
Arm Goes "Dead" After Trauma				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

UPPER ARMS / FOREARMS	YES	NO	DATE	COMMENTS
Sprain / strain				
Calcium Deposits				
Casted				
Bruise				
Injections				
Pains				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Numbness in Fingers				
Other				

ORTHOPEDIC HISTORY QUESTIONNAIRE 3

ELBOWS	YES	NO	DATE	COMMENTS
Sprain / Strain				
Bursitis				
Dislocations				
Joint Locking				
Casted				
Tendinitis				
Bruise				
Swelling				
Injections				
Pains				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

WRISTS	YES	NO	DATE	COMMENTS
Sprain / Strain				
Tendinitis				
Dislocations				
Casted				
Bruise				
Injections				
Pains				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

HANDS / FINGERS	YES	NO	DATE	COMMENTS
Sprain / Strain				
Dislocations				
Casted / Splints				
Bruise				
Injections				
Pains				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

ORTHOPEDIC HISTORY QUESTIONNAIRE 4

PELVIS / HIPS	YES	NO	DATE	COMMENTS
Sprain / Strain				
Groin Pulls				
Torn Muscles				
Dislocations				
Casted				
Bruise				
Injections				
Pains				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

THIGHS	YES	NO	DATE	COMMENTS
Sprain / Strain				
Quadriciceps Pull				
Hamstring Pull				
Torn Muscles				
Calcium Deposits				
Bruise				
Injections				
Pains				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

ORTHOPEDIC HISTORY QUESTIONNAIRE 5

KNEES	YES	NO	DATE	COMMENTS
Strain Muscle				
Sprain Ligament				
Torn Ligament				
Torn Cartilage				
Knee Cap Injury				
Knee Cap Dislocation				
Osgood Schlatter's				
Bursitis				
Swelling				
Locking				
Giving Away				
Sudden Weakness, Shifting				
Wear Braces				
Casted				
Arthritis				
Chondromalacia				
Grinding				
Tendinitis				
Jumper's Knee				
Bruise				
Pains				
Pain with Stairs				
Pain with Squats				
Fractures				
Arthrograms				
X-rays, CT, MRI				
Hospitalized				
Arthroscopes				
Surgery				
Missed Practice				
Missed Games				
Injections				
Other				

LOWER LEGS	YES	NO	DATE	COMMENTS
Sprain / Strain				
Shin Splints				
Torn Muscles				
Bruise				
Injections				
Pains				
Painful- Tight Calf w/ Activity				
Achilles Tendon Pain				
Stress Fractures				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

ORTHOPEDIC HISTORY QUESTIONNAIRE 6

ANKLES	YES	NO	DATE	COMMENTS
Sprain / Strain				
Dislocations				
Casted / Splinted				
Bruise				
Instability				
Giving Out				
Weakness				
Injections				
Pains				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

FEET / TOES	YES	NO	DATE	COMMENTS
Sprains				
Turf Toe				
Dislocations				
Casted / Splinted				
Bruise				
Injections				
Pains				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

List any special protective equipment you require or would like to have provided:

ORTHOPEDIC HISTORY QUESTIONNAIRE 7

	Please check one:	YES	NO
Have you had or do you have now any other medical problems or injuries not listed on this form?			
Do you have any medical or health problems that you are currently receiving medical treatment for ?			
Is there any reason that you are not able to participate in athletics?			
Are there any additional health problems you would prefer to discuss privately and confidentially with our team physician?			
Have you ever been hospitalized for problem not already explained in this medical/orthopedic questionnaire?			

If any of the first five questions above were answered “YES,” please explain below:

- The undersigned, herewith,
- A. Understands that he/she must refrain from practice or play during medical treatment until he/she is discharged from treatment or given a written permit by the attending physician to resume participation.
 - B. Certifies that the answers to these questions are correct and true.
 - C. Understands that his/her having passed the physician examination does not necessarily mean that he/she is physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify him/her.
 - D. Fully realizes that Wright State University cannot be held responsible for any previous medical condition(s) that he/she might have.

SIGNATURE: _____ **DATE:** _____

Team Physician Clearance

As a current or prospective student-athlete at Wright state University, I understand and agree to the following:

Wright State University has designated “Team Physicians”. The physician has final approval or disapproval of my participation in intercollegiate athletics at Wright State. This includes, but is not limited to, pre-participation exam and illness or injury prior to, during and post season. This decision may be in lieu of or in addition to recommendation by other physicians.

Print Name _____ Signature _____ Date _____

Upon completion of the History Form, it is to be reviewed and signed by a Staff Trainer.

SIGNATURE: _____ **ATC/L** **DATE:** _____

**GENERAL PHYSICAL EXAM
PHYSICIAN ONLY**

Name:		SS# - -		Date:	
Sport:		Height:		Weight:	
Pulse:		BP: /		Arm Span:	

Gross Visual Acuity:	R. Eye	Uncorrected	/	Corrected	/
	L Eye	Uncorrected	/	Corrected	/

DEFECTS OR SIGNIFICANT HISTORY:

	NL	ABNL	COMMENTS
Head: Hair, Scalp, Masses			
Eyes: Pupils, Reflex, Lids, Conjunctivae, Sclera, Peripheral Vision			
Ears: Canal, Drum, Hearing, Discharge			
Nose: Septum, obstruction, Mucosa, Polyps, Sinuses			
Mouth: Lesions, Teeth, Tongue			
Throat: Tonsils, Lesions			
Neck: Adenopathy, Thyroid, Vessels, Masses, Voice			
Chest/ Lungs: Shape, Expansion, Deformities, Ribs, Masses, Wheezes, Rales			
Heart: Murmurs, Chest Wall Tenderness, Arrhythmia, Femoral Pulses			
Abdomen: Organomegaly, Masses, Tenderness, Hernias, Scars			
Scrotum(Men Only): Lesions, Swelling, Tenderness			
Skin: Rashes, Lesions			
Skeleton: Marfan's Stigmata Arm Span: _____ Thumb Test: Yes No Wrist Test: Yes No			

PHYSICIANS SUMMARY:

[] CLEARED [] HOLD FOR FURTHER TESTING [] NOT CLEARED

PHYSICIAN SIGNATURE: _____

**ORTHOPEDIC EXAMINATION
TO BE COMPLETED BY PHYSICIAN**

DEFECTS OR SIGNIFICANT HISTORY:

	NL	ABNL	COMMENTS
Head & Neck:			
Spine:			
Cervical			
Thoracic			
Lumbar			
Shoulder: Apprehension, Impingement, Instability, Deformity, Atrophy			
Elbow:			
Arm:			
Wrist, Hand, & Fingers:			
Pelvis:			
Low. Ext.: Neuro: Gait, D.T.R.			
Hamstring: Flexibility, Deformity, Asymmetry, Atrophy			
Quadriceps: Deformity Asymmetry, Atrophy			
Ankle: Laxity, Swelling, Deformity			
Foot & Toes:			
Skin:			

Knee	LCL	RIGHT				LEFT							
		Neg	1+	2+	3+	Neg	1+	2+	3+				
	Extension	Neg	1+	2+	3+	Neg	1+	2+	3+				
	30° Flexion	Neg	1+	2+	3+	Neg	1+	2+	3+				
	MCL	RIGHT				LEFT							
	Extension	Neg	1+	2+	3+	Neg	1+	2+	3+				
	30° Flexion	Neg	1+	2+	3+	Neg	1+	2+	3+				
	ACL/ PCL	RIGHT				End Pt.	LEFT				End Pt.		
	Lachman	Neg	1+	2+	3+	Y	N	Neg	1+	2+	3+	Y	N
	Anterior Drawer	Neg	1+	2+	3+	Y	N	Neg	1+	2+	3+	Y	N
	Posterior Drawer	Neg	1+	2+	3+	Y	N	Neg	1+	2+	3+	Y	N
	Pivot Shift	Neg	Trace	1+	2+	Positive		Neg	Trace	1+	2+	Positive	
	Joint Line Tenderness		Yes		No								
	Effusion		Yes		No								
	ROM		Normal		Abnormal								
	Patella:												
	Retropatella Crepitus		Yes		No								
	Patellar Femoral Apprehension		Yes		No								
	Positive One Leg Squat		Yes		No								

PHYSICIANS SUMMARY / X-RAY EXAMINATION:

CLEARED

NOT CLEARED

PHYSICIAN SIGNATURE: _____



Assumption of Risk/Release of Claims

I, _____, am currently a student at Wright State University. I am a prospective student-athlete for the University's _____ team. Wright State University will allow me to use the University's facilities during my tryout with the team.

I understand injury is an inherent aspect of sport. I understand that through my participation in the intercollegiate athletic program at Wright State University I am subject to the possibility of injury, and also understand that by my participation, I accept the risk of possible injury. **I also understand that I assume any and all expenses I may incur as a result of injuries during my tryout.**

I recognize that Wright State University has required me to obtain a physical. I certify that all information given is true and accurate. I also certify that I am in a physical condition which allows me to participate in the workouts for the University team.

In consideration for participating in team activities, I, myself, my executors, and administrators release Wright State University from all liability for losses, damages, injuries or costs that may arise from my participation in University athletics. I understand I am giving up my right to sue Wright State University for any such losses, damages, injury or costs that I may incur.

I agree to acquire or maintain a policy of health and accident insurance during the period of my participation in team practices and workouts. Such insurance shall be through an insurance company authorized to do business in the state of Ohio.

I certify that I am 18 years of age, or if under age 18, that my parent or legal guardian has agreed to the above terms.

Print name _____

Date _____

Signature _____

Parent/Guardian _____