

University of St. Thomas

Athletic Department "Medical History Form"

| | | | | | |
|------------------------|-------------------|---------------|--------------------------|---|--|
| Name (Please print) | | | Sport | | Date |
| Home Street Address | | UST Mail # | City | | State |
| Local Phone () | Home Phone () | Date of Birth | Student Identification # | Year in School <input type="checkbox"/> FR <input type="checkbox"/> SO <input type="checkbox"/> JR <input type="checkbox"/> SR | |
| | | | | | Sex <input type="checkbox"/> M <input type="checkbox"/> F |

History of Injuries: Any previous injury resulting in loss of time from practice or game? Yes No If yes, explain below

| | |
|---|-----------------------|
| Head/Neck _____ | Date of Injury: _____ |
| Back/Chest/Abdomen _____ | Date of Injury: _____ |
| Upper Extremity _____ | Date of Injury: _____ |
| Lower Extremity _____ | Date of Injury: _____ |
| Surgery or hospitalization (Type) _____ | (Date) _____ |

Personal History: Have you experienced any of the following? Please comment on any "Yes" answers below.

| | | |
|---|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No Anxiety Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No Back Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Pressure, High <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Pressure, Low <input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain/Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Chronic Cough <input type="checkbox"/> Yes <input type="checkbox"/> No Depression <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Dysmenorrhea, Cramps <input type="checkbox"/> Yes <input type="checkbox"/> No Excessive flow <input type="checkbox"/> Yes <input type="checkbox"/> No Irregular flow <input type="checkbox"/> Yes <input type="checkbox"/> No Dizziness/Fainting <input type="checkbox"/> Yes <input type="checkbox"/> No Ear Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you require signing? <input type="checkbox"/> Yes <input type="checkbox"/> No Eye Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Do you require a reader? <input type="checkbox"/> Yes <input type="checkbox"/> No Eating disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Anorexia Nervosa <input type="checkbox"/> Yes <input type="checkbox"/> No Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No Gall Bladder Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Gum/Dental Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Headache (Recurrent) <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No HIV Infection <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Malaria <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Illness <input type="checkbox"/> Yes <input type="checkbox"/> No Mononucleosis | <input type="checkbox"/> Yes <input type="checkbox"/> No Mood Swings <input type="checkbox"/> Yes <input type="checkbox"/> No Muscle/Bone Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Nasal Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Palpitations <input type="checkbox"/> Yes <input type="checkbox"/> No Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Seasonal Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Substance Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No Sleep Disturbance <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Throat Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Tumor/Cancer/Cyst |
|---|--|---|

Explanation of Yes answers.

All known Allergies: _____

Are you taking any medication? Yes No List _____

Have you ever had any reactions to medication? Yes No Do you wear contact lenses? Yes No

Any Physical or Mental disorders **NOT** brought out by this exam? Yes No List:

Are you presently under the care of a physician? Yes No If **yes**, explain below (give Dr. name, and address)

Dr. Name _____ Clinic/Address _____

I give my consent for the athletic trainers and team physicians to use their own judgment I securing medical aid/ambulance. Yes No

To the best of my knowledge, I have given true and complete information
SIGNATURE OF ATHLETE: _____ DATE: _____