TU Athletic Training Program - Medical History Form

Name _____ Date _____
Last First MI

Explain all "Yes" answers at bottom of page

		YES	NO
1.	Have you had a medical illness or injury since your last check-up or sports physical?	☐	☐
2.	Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
3.	Do you have any ongoing or chronic illness like diabetes or epilepsy?	☐	☐
4.	Are you currently taking any prescriptions (including female hormones/oral contraceptive) or non-prescription (over the counter) medications, pills?	☐	☐
5.	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
6.	Do you have seasonal allergies that require medical treatment?	☐	☐
7.	Do you have allergies to <u>any</u> medications, pollens, foods or stinging insects?	☐	☐
8.	Have you ever developed hives with exercise?	☐	☐
9.	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
10.	Have you ever passed-out or nearly passed-out during or after exercise?	☐	☐
11.	Have you ever been dizzy during or after exercise?	☐	☐
12.	Have you ever had chest pain during or after exercise?	☐	☐
13.	Have you ever had racing of the heart or had your heart skip heartbeats?	☐	☐
14.	Do you get tired more quickly than your friends do during exercise?	☐	☐
15.	Have you ever been told that you have high blood pressure, high cholesterol, a heart murmur, or heart infection?	☐	☐
16.	Have you had any tests for your heart? (EKG or Echocardiogram?)	☐	☐
17.	Does anyone in your family have any heart problems?	☐	☐
18.	Has any family member or relative died of heart problems or died suddenly before the age of 50?	☐	☐
19.	Does anyone in your family have Marfan syndrome?	☐	☐
20.	Have you ever spent the night in a hospital?	☐	☐
21.	Have you ever had surgery?	☐	☐
22.	Have you ever had a sprain, strain, or tendonitis that caused you to miss a practice or competition?	☐	☐
23.	Have you broken or fractured any bones or dislocated any joints?	☐	☐
24.	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐
25.	Have you ever had a stress fracture?	☐	☐
26.	Have you ever had an injury that required x-rays, MRI, CT, surgery, injections, physical therapy, a brace, a cast, or crutches?	☐	☐
27.	Do you regularly use any braces or assistive devices (ex: knee brace, special neck roll, foot orthotics, retainer on your teeth, or hearing aid)?	☐	☐

If yes to any of questions # 22-27, please check appropriate box and explain below:

□ Head	□ Chest	□ Elbow	□ Hand	□ Thigh	□ Ankle
□ Neck	□ Shoulder	□ Forearm	□ Finger	□ Knee	□ Shin/Calf
□ Back	□ Upper Arm	□ Wrist	□ Hip	□ Foot	

		YES	NO
28.	Has a doctor ever told you that you have asthma?	☐	☐
29.	Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
30.	Is there anyone in your family who has been diagnosed with asthma?	☐	☐
31.	Have you ever used an inhaler or taken asthma medicine?	☐	☐
32.	Were you born without, or are you missing a kidney, eye, testicle, or any other organ?	☐	☐
33.	Have you had a severe viral infection (ex: myocarditis or infectious mononucleosis) within the last month?	☐	☐
34.	Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus, infections, or blisters)?	☐	☐
35.	Have you ever had a head injury or concussion?	☐	☐
36.	Have you ever been knocked-out, become unconscious or lost your memory?	☐	☐
37.	Have you ever had a seizure?	☐	☐
38.	Do you have frequent or severe headaches?	☐	☐
39.	Have you ever had numbness, tingling, or weakness in your arms, hands, legs, or feet?	☐	☐
40.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
41.	Have you ever had a stinger, burner, or pinched nerve?	☐	☐
42.	When exercising in the heat have you ever had severe muscle cramps, fainting, or become ill?	☐	☐
43.	Has a doctor ever told you or anyone in your family that you have sickle cell trait or sickle cell disease?	☐	☐
44.	Have you had problems with your eyes or vision?	☐	☐
45.	Do you wear glasses, contact, or protective eyewear (ex: goggles)?	☐	☐
46.	Have you ever had a broken, chipped, or loose tooth or dental plate?	☐	☐
47.	Are you satisfied with your body shape and size?	☐	☐
48.	Are you currently trying to gain or lose weight?	☐	☐
49.	What was your highest_____ and lowest _____ body weight last year?		

<u>FEMALES ONLY (questions 53-57)</u>

50. When was your first menstrual period? _____
51. When was your most recent menstrual period? _____
52. How much time do you usually have from the start of one period to the start of another?_____
53. How many periods have you had in the last year? _____
54. Date of last pap/pelvic? _____

55. Many people feel depressed at times. Please rate any recent feelings of depression you may have had: *Use a number from 0 (none) – 10 (severe).*…… _____

56.	Do you have any other concerns you would like to discuss? (e.g. social, academic, or family issues)	☐	☐

Explain "Yes" Answers here:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student:_____ Date:_____