

# TU Athletic Training Program - Medical History Form

Name \_\_\_\_\_ Date \_\_\_\_\_  

Last
First
MI

	YES	OR	NO		YES	OR	NO
Explain all "Yes" answers at bottom of page							
1. Have you had a medical illness or injury since your last check-up or sports physical?	<input type="checkbox"/>		<input type="checkbox"/>	28. Has a doctor ever told you that you have asthma?	<input type="checkbox"/>		<input type="checkbox"/>
2. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>		<input type="checkbox"/>	29. Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>		<input type="checkbox"/>
3. Do you have any ongoing or chronic illness like diabetes or epilepsy?	<input type="checkbox"/>		<input type="checkbox"/>	30. Is there anyone in your family who has been diagnosed with asthma?	<input type="checkbox"/>		<input type="checkbox"/>
4. Are you currently taking any prescriptions (including female hormones/oral contraceptive) or non-prescription (over the counter) medications, pills?	<input type="checkbox"/>		<input type="checkbox"/>	31. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>		<input type="checkbox"/>
5. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>		<input type="checkbox"/>	32. Were you born without, or are you missing a kidney, eye, testicle, or any other organ?	<input type="checkbox"/>		<input type="checkbox"/>
6. Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>		<input type="checkbox"/>	33. Have you had a severe viral infection (ex: myocarditis or infectious mononucleosis) within the last month?	<input type="checkbox"/>		<input type="checkbox"/>
7. Do you have allergies to <u>any</u> medications, pollens, foods or stinging insects?	<input type="checkbox"/>		<input type="checkbox"/>	34. Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus, infections, or blisters)?	<input type="checkbox"/>		<input type="checkbox"/>
8. Have you ever developed hives with exercise?	<input type="checkbox"/>		<input type="checkbox"/>	35. Have you ever had a head injury or concussion?	<input type="checkbox"/>		<input type="checkbox"/>
9. Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>		<input type="checkbox"/>	36. Have you ever been knocked-out, become unconscious or lost your memory?	<input type="checkbox"/>		<input type="checkbox"/>
10. Have you ever passed-out or nearly passed-out during or after exercise?	<input type="checkbox"/>		<input type="checkbox"/>	37. Have you ever had a seizure?	<input type="checkbox"/>		<input type="checkbox"/>
11. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>		<input type="checkbox"/>	38. Do you have frequent or severe headaches?	<input type="checkbox"/>		<input type="checkbox"/>
12. Have you ever had chest pain during or after exercise?	<input type="checkbox"/>		<input type="checkbox"/>	39. Have you ever had numbness, tingling, or weakness in your arms, hands, legs, or feet?	<input type="checkbox"/>		<input type="checkbox"/>
13. Have you ever had racing of the heart or had your heart skip heartbeats?	<input type="checkbox"/>		<input type="checkbox"/>	40. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>		<input type="checkbox"/>
14. Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>		<input type="checkbox"/>	41. Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>		<input type="checkbox"/>
15. Have you ever been told that you have high blood pressure, high cholesterol, a heart murmur, or heart infection?	<input type="checkbox"/>		<input type="checkbox"/>	42. When exercising in the heat have you ever had severe muscle cramps, fainting, or become ill?	<input type="checkbox"/>		<input type="checkbox"/>
16. Have you had any tests for your heart? (EKG or Echocardiogram?)	<input type="checkbox"/>		<input type="checkbox"/>	43. Has a doctor ever told you or anyone in your family that you have sickle cell trait or sickle cell disease?	<input type="checkbox"/>		<input type="checkbox"/>
17. Does anyone in your family have any heart problems?	<input type="checkbox"/>		<input type="checkbox"/>	44. Have you had problems with your eyes or vision?	<input type="checkbox"/>		<input type="checkbox"/>
18. Has any family member or relative died of heart problems or died suddenly before the age of 50?	<input type="checkbox"/>		<input type="checkbox"/>	45. Do you wear glasses, contact, or protective eyewear (ex: goggles)?	<input type="checkbox"/>		<input type="checkbox"/>
19. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>		<input type="checkbox"/>	46. Have you ever had a broken, chipped, or loose tooth or dental plate?	<input type="checkbox"/>		<input type="checkbox"/>
20. Have you ever spent the night in a hospital?	<input type="checkbox"/>		<input type="checkbox"/>	47. Are you satisfied with your body shape and size?	<input type="checkbox"/>		<input type="checkbox"/>
21. Have you ever had surgery?	<input type="checkbox"/>		<input type="checkbox"/>	48. Are you currently trying to gain or lose weight?	<input type="checkbox"/>		<input type="checkbox"/>
22. Have you ever had a sprain, strain, or tendonitis that caused you to miss a practice or competition?	<input type="checkbox"/>		<input type="checkbox"/>	49. What was your highest _____ and lowest _____ body weight last year?			
23. Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>		<input type="checkbox"/>	<b>FEMALES ONLY (questions 53-57)</b>			
24. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>		<input type="checkbox"/>	50. When was your first menstrual period? _____			
25. Have you ever had a stress fracture?	<input type="checkbox"/>		<input type="checkbox"/>	51. When was your most recent menstrual period? _____			
26. Have you ever had an injury that required x-rays, MRI, CT, surgery, injections, physical therapy, a brace, a cast, or crutches?	<input type="checkbox"/>		<input type="checkbox"/>	52. How much time do you usually have from the start of one period to the start of another? _____			
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)?	<input type="checkbox"/>		<input type="checkbox"/>	53. How many periods have you had in the last year? _____			
If yes to any of questions # 22-27, please check appropriate box and explain below:				54. Date of last pap/pelvic? _____			
<input type="checkbox"/> Head	<input type="checkbox"/> Chest	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hand	<input type="checkbox"/> Thigh	<input type="checkbox"/> Ankle		
<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Forearm	<input type="checkbox"/> Finger	<input type="checkbox"/> Knee	<input type="checkbox"/> Shin/Calf		
<input type="checkbox"/> Back	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Wrist	<input type="checkbox"/> Hip	<input type="checkbox"/> Foot			
				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)	<input type="checkbox"/>		<input type="checkbox"/>

**Explain "Yes" Answers here:**

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

Signature of AT Student: \_\_\_\_\_ Date: \_\_\_\_\_