

The University of Tennessee at **CHATTANOOGA**

2006-2007 Medical History Information Record

Name: _____ Sport(s): _____
(LAST) (FIRST) (MIDDLE) (NICKNAME)

SSN: _____ Date of Birth: ____/____/____ Sex: ____ Race: _____
(Student number if no SSN) MONTH / DAY / YEAR

Local address, Apartment, Dormitory, etc. _____

Local Phone: _____ Cell Phone: _____ E-Mail: _____

I. Person to notify in case of an Emergency:

_____ Relationship: _____

Address: _____
(City) (State) (Zip)

Home Phone: (____) _____

Business Phone: (____) _____

II. Father's Name:

Address: _____

(City) (State) (Zip)

Home Phone:(____) _____

Business Phone:(____) _____

Cell Phone: (____) _____

III. Mother's Name:

Address: _____

(City) (State) (Zip)

Home Phone:(____) _____

Business Phone:(____) _____

Cell Phone: (____) _____

IV. Spouse's Name:

Address: _____

(City) (State) (Zip)

Home-Phone: (____) _____

Business Phone: (____) _____

V. Name of family Physician:

Address: _____

(City) (State) (Zip)

Business Phone: (____) _____

Fax: (____) _____

VI. High School:

Address: _____
(City) (State) (Zip)

Coach's Name: _____

Athletic Trainer's Name: _____

VII. Previous College:

Address: _____
(City) (State) (Zip)

Coach's Name: _____

Athletic Trainer's Name: _____

A. FAMILY MEDICAL HISTORY: Has any blood relative ever had?

Cancer	YES	NO	Stroke	YES	NO	Alcoholism/Drug Abuse	YES	NO
Diabetes	YES	NO	Epilepsy/Seizures	YES	NO	Die suddenly before age 50 years	YES	NO
Heart Trouble	YES	NO	Mental Illness/Depression	YES	NO	Sickle Cell Trait/Disease	YES	NO
High Blood Pressure	YES	NO	Suicide	YES	NO	Bleeding Disorder/Blood Disease	YES	NO
Other, please explain:						Blood type: A+ A- B+ B- AB+ AB- O+ O-		

B. MEDICAL ILLNESS HISTORY **NOTE: This information will be kept CONFIDENTIAL!!!

1. Have you ever had or do you now have any of the conditions below? If so, check yes. If not, check no.
2. If yes, put your age the condition occurred at in the appropriate box.

CHECK EACH ITEM	AGE	YES	NO	CHECK EACH ITEM	AGE	YES	NO	CHECK EACH ITEM	AGE	YES	NO
3-Day Measles				Goiter/Thyroid Disease				Pneumonia			
Amnesia				Headaches (Frequent)				Polio			
Appendicitis				Hemophilia				Rectal Bleeding			
Arthritis				Hemorrhoids				Rheumatic Fever			
Asthma				Hepatitis				Rheumatism			
Bloody Urine/Stool				Indigestion (Frequent)				Scarlet Fever			
Bronchitis				Influenza				Severe Car/Air/Motion Sickness			
Cancer				Insomnia				Sickle Cell Anemia/Trait			
Chicken Pox				Jaundice				Sinusitis			
Chronic Cough				Kidney Stones				Shortness of Breath			
Chronic Frequent Colds				Kidney Trouble				Skin Disorders			
Constipation (Frequent)				Liver Trouble				Small Pox			
Depression				Malaria				Soaking Night Sweats			
Diarrhea (Frequent)				Migraine Headaches				Staph Infection			
Diphtheria				Mononucleosis				Swimmer's Ear			
Dizziness				Mumps				Tuberculosis			
Eating Disorder				Nervous Stomach				Tumor/Growth/Cyst			
Epilepsy/Seizures				Obesity				Typhoid Fever			
Excessive Worry/Nervousness				Pain/Pressure in Chest				Urination (Frequent)			
Exercise Induced Asthma				Painful Urination				Whooping Cough			
Fever Blisters				Palpitation/Pounding Heart							
Gallbladder Trouble				Paralysis							
Gallstones				Peptic Ulcer							

C. GENERAL MEDICAL ALLERGIES: Please answer as to whether you are allergic to the following items?

Aspirin	YES	NO	Penicillin	YES	NO	Tetanus antitoxin or serums	YES	NO	Bee stings	YES	NO
Codeine	YES	NO	Any other drug	YES	NO	Novocain or other anesthetics	YES	NO	Fire ant bites	YES	NO
Sulfa Drugs	YES	NO	Any foods	YES	NO	Hay Fever – dust/mold/pollen/grass	YES	NO			
1. Are you allergic to any other medications, foods, plants, insects, etc. not listed above? If yes, please list those allergies here:										YES	NO
2. Have you ever had any reaction to Serum Drugs? If yes, please list the drugs and related details here:										YES	NO

*****ONLY FEMALES ANSWER THIS SECTION*****

D. GYNECOLOGICAL HISTORY:

CHECK YES OR NO FOR THE FOLLOWING & IF THE ANSWER IS YES, WRITE IN THE AGE AT WHICH THE CONDITION OCCURRED.

	Number	Date	Age		Yes	No	Age		Yes	No	Age
Number of Pregnancies				Scanty Flow				Vaginal Discharge			
Number of Births				Excessive Flow				Painful Menstruation			
Number of Miscarriages				Lumps in Breast				Pre-menstrual Tension			
Abnormal Pap Smears				Age Periods Began				Frequent Urinary Tract Infections			
Last Pap Smear				Endometriosis				Irregular Periods			
Last Period											

E. GENERAL MEDICAL INFORMATION: (CIRCLE THE CORRECT ANSWER)

1. Are you a Diabetic or ever been treated for Diabetes. If yes, please list the age at which your diabetes began as well as any and all medications you take for this condition:						YES	NO
2. Do you or have you ever had Anemia?		YES	NO	Do you or have you ever had Hypoglycemia (Low Blood Sugar)?		YES	NO
3. Do you have a Heart Disease? If yes, please list any medications taken for this condition:		YES	NO	Heart Disorder? If yes, please list any medications taken for this condition:		YES	NO
4. Do you have High Blood Pressure (Hypertension)?		YES	NO	Do you have Low Blood Pressure (Hypotension)?		YES	NO
5. Please list any and all medications you take for High or Low Blood Pressure including the names, dosages, and how often you take them:							
6. Do you have a vision defect in either one or both eyes and if yes, please specify below:						YES	NO
7. Do you wear glasses?							
8. If yes, do you wear them during practice?		YES	NO	If yes, do you wear them during games?		YES	NO
9. Do you wear contact lenses?							
10. If yes, do you wear them during practice?		YES	NO	If yes, do you wear them during games?		YES	NO
11. Have you ever had glaucoma?		YES	NO	Have you ever had retinal detachment?		YES	NO
12. Do you have a hearing defect and if yes, please specify below and list any hearing aids worn:						YES	NO
13. Do you wear any dental/orthodontic appliances?		YES	NO	If so, do you wear them during practice?		YES	NO
14. If yes, please list the appropriate appliance:							
15. Do you have any severe Tooth and Gum Trouble and if yes, please list details below:						YES	NO
16. In the past 3 years have you had your Tetanus shot?			YES	NO	Toxoid shot?	YES	NO
17. Have you ever had trouble with dehydration? (Excess Loss of Salt & Water)						YES	NO
18. Have you ever had Heat Cramps?		YES	NO	Heat Exhaustion?		YES	NO
19. Have you Passed Out or had Fainting Spells?		YES	NO	Did this occur with physical activity?		YES	NO
20. Have you ever had a Concussion? If yes, please list the number of times and severity of each below:						YES	NO
If yes, were you ever hospitalized for any of the concussions you sustained?						YES	NO
21. Have you ever had a Skull Fracture?		YES	NO	Double Vision?		YES	NO
22. Have you ever been knocked unconscious? If yes, please list the number of times and which ones you were hospitalized for?						YES	NO
23. Were you born with a complete and functional set of paired organs? (Eyes, Ears, Kidneys, Ovaries/Testicles, Lungs)						YES	NO
24. Have you ever lost the full use of the following organs, either temporarily or permanently? (Ears, Eyes, Kidneys, Lungs, Testicles(male), Ovaries(female) If yes, please list the organ(s) and details regarding the loss including the dates and treating physicians for each:						YES	NO
25. Have you ever had surgery to repair or remove any organ? If yes, please list the organ(s) and details regarding the repair and/or removal including the dates and treating physicians for each:						YES	NO
26. Are you an Epileptic or ever have had an Epileptic seizure and if yes, please list any and all medications you take for this condition:						YES	NO
27. Did you ever have spasms or convulsions as an infant?							
28. Do you have a Hernia?							
29. In the past 12 months have you been treated for Mononucleosis?			YES	NO	Pneumonia?	YES	NO
30. Do you currently take any medicines or drugs? If yes, what medication or drug are you taking, and for what reason?						YES	NO

F. NUTRITION, DRUGS, FOOD SUPPLEMENTS, AND MISCELLANEOUS AGENTS:

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

	NEVER	RARELY	OCCASIONALLY	FREQUENTLY
Stimulants (Benzedrine, Amphetamines, etc.)				
Chewing Tobacco				
Cigarettes, Cigars, or Pipe				
Vitamins				
Sleeping Pills				
Diet Pills				
Alcoholic Beverages				
Anabolic Steroids (growth stimulants)				
Snuff and Smokeless Tobacco				
Amino Acids				
Creatine phosphate				

1. Have you ever had a problem with food bingeing? If yes, when?	YES	NO
2. Has it ever been suggested or have you ever been diagnosed as being anorexic? If yes, when?	YES	NO
3. Have you ever been diagnosed as bulimic or having bulimia? If yes, when?	YES	NO
4. Do you sometimes or often induce vomiting after eating?	YES	NO
5. Do you take laxatives sometimes or often to prevent being overweight?	YES	NO
6. Are you happy with your weight?	YES	NO
7. Do you feel pressured to keep your weight low?	YES	NO

G. NON-ATHLETIC SURGERY:

Have you have ever had any non-athletic surgeries? List them below:

DATES	SURGICAL PROCEDURES	PHYSICIANS	COMPLICATIONS

H. ORTHOPEDIC MEDICAL HISTORY:

I. FRACTURES:

1. Have you ever broken (fractured) a bone? If yes, please fill in the appropriate boxes below:						YES	NO
BODY PART	DATES	BODY PART	RIGHT	LEFT	DATES		
SKULL		COLLAR BONE					
NOSE		UPPER ARM					
FACE		FOREARM					
JAW		WRIST					
NECK		HAND					
SPINE		THIGH					
PELVIS		LOWER LEG					
RIBS		FOOT					
FINGERS	R _____	thumb _____, 2 _____, 3 _____, 4 _____, 5 _____	L _____	thumb _____, 2 _____, 3 _____, 4 _____, 5 _____			
TOES	R _____	1 _____, 2 _____, 3 _____, 4 _____, 5 _____	L _____	1 _____, 2 _____, 3 _____, 4 _____, 5 _____			
2. Do you have any residual defect or problem as a result of a fracture(s)? If yes, please explain.						YES	NO
3. Did the fracture require surgery? If yes, please describe the type of surgery, date, physician, and location of the hospital.						YES	NO

II. MUSCLE INJURIES:

1. Have you ever had a severe muscle pull or strain?	YES	NO
2. Has this injury re-occurred? If yes, list muscle(s) was involved and date(s):	YES	NO

III. DISLOCATIONS:

1. Have you ever dislocated a joint? If yes, please fill out the appropriate boxes on the chart below:	YES	NO							
	RIGHT	LEFT	# OF TIMES	DATES		RIGHT	LEFT	# OF TIMES	DATES
SHOULDER					ELBOW				
A-C JOINT					WRIST				
KNEE CAP					HIP				
KNEE					FINGERS				
NECK					TOES				
ANKLE									
2. If you have ever had surgery for your dislocation, please describe the type of surgery. List date, physician, and the location of the hospital below:									

IV. CALCIUM DEPOSITS - BONE SPURS:

1. Have you ever had a calcium deposit form in your thigh or anywhere else following a bad bruise? If yes, where is the calcium deposit located?	YES	NO
2. Have you ever had a bone spur develop and if so, where?	YES	NO
3. Did the calcium deposit or bone spur require surgical removal? If so, give the date, physician, and location of hospital.	YES	NO

V. NECK:

1. Have you ever sustained a serious neck or cervical injury?	YES	NO			
2. Did you have numbness, burning, or sharp pain in your arms or legs?	YES	NO			
3. Have you ever had neck surgery? If yes, list surgery type, date, physician, and location of hospital below:	YES	NO			
4. Do you wear a neck or cowboy collar because of an injury?	YES	NO			
5. Have you ever had a neck or spinal injury?	YES	NO	If yes, did you have neck or spinal X-Rays taken?	YES	NO
If yes, did you have a neck or spinal fracture?		YES	NO		
6. Have you ever had an injury producing weakness or numbness of either your arms or legs or both?	YES	NO			
7. Have you ever had a burner or stinger (stretched or pinched nerve)?	YES	NO			
8. Have you ever had recurrent burners or stingers?	YES	NO			
9. Do you currently have any weakness due to a neck or spinal injury? If yes, give the location(s) of the weakness.	YES	NO			

VI. SPINE:

1. Have you ever injured your back?	YES	NO	Have you ever injured your back more than once?	YES	NO			
2. Do you or did you ever have numbness or tingling running down into your leg(s)?	YES	NO						
3. When did you first have back trouble (circle the appropriate time(s) and elaborate)?								
Before High School?	YES	NO	During High School?	YES	NO	During College?	YES	NO
4. Were you ever diagnosed with a spinal defect of any type?	YES	NO						
5. Have you ever had a spinal fracture?	YES	NO						
6. Have you ever had back surgery? If yes, list surgery type, date, physician, and location of hospital below.	YES	NO						

VII. SHOULDER:

1. Have you ever had a significant shoulder joint injury?	L	R	YES	NO
2. Have you ever had an A-C sprain or separation?	L	R	YES	NO
3. Have you ever had the feeling that your shoulder is coming out of place?	L	R	YES	NO
4. Have you ever had a problem with your shoulder repeatedly coming out of place?	L	R	YES	NO
5. Do you have any problems with your shoulder when trying to throw?	L	R	YES	NO
6. Have you ever had shoulder surgery? If yes, list surgery type, date, physician, and the location of hospital below.	L	R	YES	NO

VIII. KNEE:

1. Have you ever had a significant knee injury? If yes, please describe the injury(s) you have sustained?	L	R	YES	NO
A. Were you placed on a rehabilitation program?			YES	NO
B. Are you currently still on this rehabilitation program?			YES	NO
2. Does your knee ever swell or collect fluid?	L	R	YES	NO
3. Have you ever suffered from patellar tendonitis or jumper's knee?	L	R	YES	NO
4. Have you ever been diagnosed with Osgood-Schlatter's disease?	L	R	YES	NO
5. Have you ever sustained a dislocated patella(s) (knee cap)?	L	R	YES	NO
6. Do you ever experience any episodes of locking, catching, slipping, or giving away? If yes, please describe.	L	R	YES	NO
7. Did you have surgery for your knee injury(s)? If yes, please describe the surgery type, date, physician, and the location of the hospital where surgery was performed	L	R	YES	NO
8. Have you had surgery to either knee more than once?	L	R	YES	NO
If you have had knee surgery, answer the following questions:			YES	NO
A. Were you placed on a rehabilitation program?			YES	NO
B. Are you currently still on this rehabilitation program?			YES	NO
C. Do you wear any type of preventative/protective brace when you practice or play?			YES	NO

IX. ANKLES:

1. Have you ever sustained a severe ankle sprain?	L	R	YES	NO
2. Do you have any residual problems with your ankle(s)?	L	R	YES	NO
3. Have you ever had surgery on your ankle(s)? If yes, describe the surgery type, date, physician, and location of the hospital below.	L	R	YES	NO
4. Do you wear any type of preventative/protective brace during practice or play?	L	R	YES	NO
5. Do you commonly have your ankle(s) taped during practice or play?	L	R	YES	NO

X. FEET AND TOES

1. Do you have a problem with athlete's foot?	L	R	YES	NO
2. Have you ever had a problem with bunions?	L	R	YES	NO
3. Have you ever had a fallen arch?	L	R	YES	NO
4. Have you ever had a problem with turf toe or sprained great toe?	L	R	YES	NO
5. Have you ever had a problem with ingrown toenails?	L	R	YES	NO

If you have any additional conditions, problems, or comments that are or have not been addressed in the above questionnaire, please use the space below to inform us so that we may be able to better serve you with our best medical care.

All statements and answers in the above medical history questionnaire are true and complete to the best of my knowledge. I have no abnormality, limitation, or restriction not mentioned in this record. I understand that this information is to help determine my fitness to participate in athletics, and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur.

DATE _____ **PRINTED NAME OF ATHLETE** _____
(First) (Middle) (Last)

DATE _____ **SIGNATURE OF ATHLETE** _____