UNIVERSITY OF IOWA SPORTS MEDICINE

ATHLETIC TRAINING SERVICES

MEDICAL HISTORY AND INFORMATION FORM

Print Form

Student-Athlete _____ Sport _____

Gender _____ Birthdate _____ Student ID # _____

Campus Address _____ City _____ State _____ Zip _____

Campus Phone _____ Cell Phone _____ Preferred Email _____

In case of emergency, contact:

Name _____ Relationship _____ Home phone _____ Cell phone _____

ALLERGIES/INTOLERANCES

Please list any allergies you have (drug, bee stings, food, tape, etc) and the type of reaction.

_____ _____ _____

_____ _____ _____

MEDICAL PROBLEMS

Please list all medical problems (disease or illness) that are currently being treated or have been treated by a physician or health care provider within the last 6 months:

_____ _____

_____ _____

_____ _____

MEDICATIONS

Please list ALL prescription and over the counter medications that you are currently taking and reason for usage.

_____ _____

_____ _____

_____ _____

SUPPLEMENTS

Please list ALL vitamins and supplements (this may include, but is not limited to, weight gain or weight loss supplements, herbs, drinks, mixes, vitamins and minerals, etc) that you are currently taking, or have taken in the last year, and reason for usage.

_____ _____

_____ _____

_____ _____

Have you ever used anabolic steroids by prescription or any other source? _____

If YES, please explain: _____

Student-Athlete _____ Sport _____

Date of most recent tetanus shot _____ **MMR Vaccine Date #1** _____ **MMR Vaccine Date # 2** _____

Please list any surgical procedures you have had, including the dates, name and address of physician

_____

_____

Have you ever been hospitalized overnight for any reason (disease, illness, or injury)? _____

If YES, please explain: _____

Were you born without or have you had any organs removed? (Kidney, Spleen, Testicle) _____

If YES, please explain: _____

Have you ever had a concussion or head injury? _____ **If YES, how many?** _____

Please provide dates for each concussion and indicate if there was any loss of consciousness. _____

_____

Have you ever fainted during participation in sports? _____ **If YES, please explain.** _____

_____

Have you OR any of your blood relatives ever had

	NO	YES	Specifics (Include who and year of diagnosis or occurrence)
Cancer	☐	☐	
High blood pressure/Hypertension	☐	☐	
Sickle Cell Trait/Disease	☐	☐	
Tuberculosis	☐	☐	
Diabetes	☐	☐	
Kidney Disease	☐	☐	
Heart Disease	☐	☐	
Marfan's Syndrome	☐	☐	
Cardiomyopathy	☐	☐	
Arthritis	☐	☐	
Stomach Disease	☐	☐	
Asthma	☐	☐	
Hay Fever	☐	☐	
Convulsive Disorders	☐	☐	
Emotional Disorders	☐	☐	
Alcohol or Substance Abuse	☐	☐	
Died less than 50 years old	☐	☐	

Student-Athlete _____ Sport _____

Has a doctor ever denied or restricted you from sport participation for any reason? _____

If YES, please explain: _____

Please answer all of the following questions	**NO**	**YES**	**If YES, please comment**
Chest pain or discomfort during or after exercise	☐	☐	
Palpations or irregular heartbeat during or after exercise	☐	☐	
Have you ever passed out during or after exercise	☐	☐	
Have you ever been dizzy during or after exercise	☐	☐	
Do you get tired more quickly than your teammates during exercise	☐	☐	
Have you ever been told you have a heart murmur	☐	☐	
Has a physician ever denied or restricted participation in activity due to any heart problems	☐	☐	
Have you ever had high cholesterol	☐	☐	
Have you had myocarditis or mono in the last month	☐	☐	
Have you ever been knocked out, became unconscious or lost your memory	☐	☐	
Have you ever had a seizure	☐	☐	
Do you have frequent or severe headaches	☐	☐	
Numbness/tingling in arms, hands, legs, or feet	☐	☐	
Have you ever had a burner, stinger, or pinched nerve	☐	☐	
Have you ever become ill from exercising in the heat	☐	☐	
Restricted from participation due to heat illness	☐	☐	
Cramps during or after exercise	☐	☐	
Heat related illness (exhaustion, stroke)	☐	☐	
Cough, wheeze, or have difficulty breathing during or after exercise	☐	☐	
Do you have hay fever or seasonal allergies that require medical treatment	☐	☐	
Do you have have any skin problems (itching, rashes, acne warts, fungus, blisters)	☐	☐	
Do you wear glasses, contacts, or protective eyewear	☐	☐	
Have you ever had any problems with your eyes or vision	☐	☐	
Have you ever had any problems with your ears or hearing	☐	☐	
Have you ever had any problems with your stomach or intestines that lasted more than 2 weeks	☐	☐	
Do you use tobacco in any form	☐	☐	
Do you consume alcoholic beverages	☐	☐	
Do you want to weigh more or less than you do now	☐	☐	
Do you use any methods to control your weight	☐	☐	

Student-Athlete _____ Sport _____

GYNECOLOGICAL (FEMALE STUDENT-ATHLETES)

	NO	YES	
Age of first menstrual period			_____
When was your last period			_____
How many periods have you had in the past 12 months			_____
Any significant menstrual irregularity	☐	☐	_____
Unusual menstrual cramps or pain	☐	☐	_____

MUSCULOSKELETAL (Please check all that apply)

	Sprain	Strain	Fracture	Stress fx	Dislocation	Specifics
Toe	☐	☐	☐	☐	☐	_____
Foot	☐	☐	☐	☐	☐	_____
Ankle	☐	☐	☐	☐	☐	_____
Shin/Calf	☐	☐	☐	☐	☐	_____
Knee	☐	☐	☐	☐	☐	_____
Thigh	☐	☐	☐	☐	☐	_____
Hamstring	☐	☐	☐	☐	☐	_____
Hip	☐	☐	☐	☐	☐	_____
Spine	☐	☐	☐	☐	☐	_____
Back	☐	☐	☐	☐	☐	_____
Finger	☐	☐	☐	☐	☐	_____
Hand	☐	☐	☐	☐	☐	_____
Wrist	☐	☐	☐	☐	☐	_____
Forearm	☐	☐	☐	☐	☐	_____
Elbow	☐	☐	☐	☐	☐	_____
Upper arm	☐	☐	☐	☐	☐	_____
Shoulder	☐	☐	☐	☐	☐	_____
Chest	☐	☐	☐	☐	☐	_____
Neck	☐	☐	☐	☐	☐	_____

Please describe any other medical condition you have not identified on this form.

_____

_____

_____

All of the above information is complete and correct to the best of my knowledge. I authorize the University of Iowa Team Physican and Athletic Training Staff to render any first aid or emergency medical care that they feel I may require. I further authorize the University of Iowa Sports Medicine Staff to provide this medical information to other health care professionals to aid in the treatment of any medical problems I may incur while paticipating as an athlete at the University of Iowa. I further agree that any medical conditions not revealed at the time of the physical examination will release the University of Iowa from any medical or financial liability.

Student Athlete Signature _____ **Date** _____