

University Sports Medicine

Club Sports History and Consent

Name _____ Age _____ Date of Birth _____

Local Address _____

Home Address _____

Local Phone # _____ Home Phone # _____

Sport _____ Grade in School _____

Date of most recent Physical Examination by Physician _____

Name of Physician who provided Physical Exam _____

History

Yes No Have you had a medical illness or injury since your last medical physical exam? Please explain in detail with dates _____

Yes No Have you been hospitalized overnight during past 12 months? Please give dates and explain _____

Yes No Have you had surgery in past 12 months? Please explain and give dates

Please list any medications you currently use including inhalers _____

Yes No Have you experienced chest pain during or after exercise in the last 12 months? Please explain _____

Yes No Do you have high blood pressure? If yes how is it treated? _____

Yes No Have you had a severe viral infection (ex. Mono) in the last 12 months? When and what? _____

Yes No Have you had a head injury or concussion in the past 12 months? Please list with specific dates and explain _____

Yes No Have you been knocked out or become unconscious in the past 12 months? Please explain and give dates _____

Yes No Have you had a seizure since your last medical physical examination? Explain _____

Yes No Have you dislocated any joint in the last 12 months? Please list with date? and treatment _____

Yes No Have you fractured any bones in the last 12 months? Please list with dates and treatment _____

Yes No Have you torn any ligaments in the past 12 months? Please list with dates and treatment _____

I, _____, acknowledge this screening tool does not replace the need for annual medical physical examination by a qualified Physician or Physician assistant.

Signature

Date