

University at Buffalo Medical History Form

Name: _____ Sex: _____ Age: _____ Date of Birth _____

Year in School: _____ Sport: _____ Person #: _____ Soc Sec #: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone (Home): _____ Phone (School): _____ Phone (cell): _____ E-Mail _____

Personal Physician: _____

In case of Emergency, contact: _____ Relationship _____ Phone: _____

EXPLAIN "YES" ANSWERS BELOW. CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWERS TO.

- | | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Do you cough, wheeze, or have difficulty breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)? | <input type="checkbox"/> | <input type="checkbox"/> | 25. Is there anyone in your family who has asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or Nonprescription medicines or pills? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have you ever used an inhaler or taken asthma medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any allergies to medicines, pollens, Foods, or stinging insects? | <input type="checkbox"/> | <input type="checkbox"/> | 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out DURING exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 28. Have you had infectious mononucleosis (mono) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out or nearly passed out AFTER exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 29. Do you have any rashes or pressure sores | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 30. Have you had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 31. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a doctor ever told you that you have (check all that apply):
__High Blood Pressure __A heart murmur
__High Cholesterol __A heart infection | <input type="checkbox"/> | <input type="checkbox"/> | 32. Have you ever been hit in the head and been confused Or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has a doctor ever ordered a test for your heart? | <input type="checkbox"/> | <input type="checkbox"/> | 33. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has anyone in your family died for no apparent reason? | <input type="checkbox"/> | <input type="checkbox"/> | 34. Do you have headaches with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does anyone in your family have a heart problem? | <input type="checkbox"/> | <input type="checkbox"/> | 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | 36. Have you ever been unable to move your arms or Legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Does anyone in your family have Marfan syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | 37. When exercising in the heat, do you have severe Muscle cramps or become ill? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever spent the night in the hospital? | <input type="checkbox"/> | <input type="checkbox"/> | 38. Has a doctor told that you or someone in your Family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 39. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had a stress fracture? | <input type="checkbox"/> | <input type="checkbox"/> | 40. Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you been told that you have or have you had An x-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> | 41. Do you wear protective eyewear, such as goggles Or a face shield | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a Practice or game? If yes, where? _____ | <input type="checkbox"/> | <input type="checkbox"/> | 42. Are you happy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you ever had any broken or fractured bones or dislocated joints? If yes, where? _____ | <input type="checkbox"/> | <input type="checkbox"/> | 43. Are you trying to lose or gain weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, Physical therapy, a brace, a cast or crutches? If yes, where? _____ | <input type="checkbox"/> | <input type="checkbox"/> | 44. Has anyone recommended you change your weight or eating habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you regularly use a brace or assistive device? | <input type="checkbox"/> | <input type="checkbox"/> | 45. Do you limit or carefully control what you eat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Has a doctor ever told you that you have asthma or Allergies? | <input type="checkbox"/> | <input type="checkbox"/> | 46. Do you have any concerns that you would like to discuss with a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | FEMALES ONLY: | | |
| | | | 47. Have you ever had a menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 48. How old were you when you had your first menstrual period? _____ | | |
| | | | 49. How many periods have you had in the last 12 months? _____ | | |

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

Name: _____ Signature: _____ Date: _____