**Doctor Check**

1._____
2._____
3._____
4._____
5._____

# Clemson Athletic Department Medical History

Date _____

Name: Last_____First_____Middle_____
SS# _____ Date of Birth _____ Age _____ Sex_____ Sport_____
Home Address _____ Home Phone # _____
City _____ State _____ Zip _____
Legal Guardian _____ Home Phone # _____
Address _____ Work Phone # _____
City _____ State _____ Zip _____
Emergency contact other than legal guardian: _____
Relationship _____ Phone # _____

Has Any Blood Relative Ever Had: (If yes, please indicate who)

| | Yes | No | Who |
|---|---|---|---|
| Sudden Death (Before age 55) | | | |
| Blood Diseases (Sickle Cell, Leukemia) | | | |
| Diabetes | | | |
| Epilepsy | | | |
| Gout | | | |
| Heart Disease (including heart attack) | | | |
| Hemophilia | | | |
| High Blood Pressure | | | |
| Mental Disorders | | | |
| Stroke | | | |
| Tuberculosis | | | |
| Drug and/or Alcohol Dependency | | | |

Allergies

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Aspirin | | | Insect Bites/Stings | | |
| Codeine | | | Tetanus Antioxin or Serums | | |
| Cortisone | | | Any Foods | | |
| Sulfa | | | Any other Drugs | | |
| Anti-Inflammatories | | | Latex | | |
| Penicillin | | | Other | | |

## General Medical

Have you ever had any of the following conditions?

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| High Blood Pressure | | | Skin Disease | | |
| Rheumatic Fever | | | Diabetes | | |
| Rheumatic Heart Disease | | | Sickle Cell Anemia/Carrier | | |
| Pericarditis | | | Anemia | | |
| Any Heart Disease? | | | Abnormal Bruising | | |
| Tumor, Growth, Cyst, Cancer | | | Abnormal Bleeding Tendency | | |
| Any ruptured organs? | | | Blood Disease | | |
| Hepatitis | | | Blood Clots | | |
| Jaundice | | | Kidney Disease | | |
| Gout | | | Kidney Stones | | |
| Pleurisy | | | Kidney Injury | | |
| Pneumonia | | | Blood in Urine | | |
| Polio | | | Frequent Urinary Infections | | |
| Bronchitis | | | Hearing Defect/Loss | | |
| Frequent Respiratory Infections | | | Ear Infection | | |
| Tuberculosis | | | Muscular Disease | | |
| Malaria | | | Birth Defects | | |
| Mumps | | | Appendicitis | | |
| Mononucleosis | | | Stomach Ulcer (Peptic) | | |
| Red Measles | | | Gastrointestinal Bleeding | | |
| Rubella | | | Constipation | | |
| Chicken Pox | | | Hemorrhoids | | |
| Asthma | | | Hernia | | |
| Exercise Induced Asthma | | | Arthritis | | |
| Recurrent Sinusitis | | | Joint Inflammation | | |
| Sinus Infection | | | Fever Blister | | |
| Nasal Polyps | | | Sexually Transmitted Diseases | | |
| Nose Fracture | | | Car or Air Sickness | | |
| Amnesia | | | Nervous Breakdown | | |
| Meningitis | | | Mental Disorder | | |
| Migraine Headaches | | | Drug Dependency | | |
| Seizure Disorder | | | AIDS/HIV positive | | |
| Goiter, Thyroid Disease | | | Heat Illness (Cramps, Exhaustion, Stroke) | | |
| ADD | | | ADHD | | |

Comments:

**General Medical Health History (continued)**

**Dental**

| | Yes | No | Comments |
|---|---|---|---|
| Do you have a bridge or false teeth? | | | |
| Have you ever fractured a tooth? | | | |
| Have you had a tooth knocked out? | | | |
| Do you wear orthodontic appliances? | | | |

**Miscellaneous**

Have you ever….?

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Worn hearing aids | | | Coughed up blood | | |
| Bled excessively after injury | | | Had pins, staples, wires in body | | |
| Been advised to have any operations | | | Had any other illness other that those already noted | | |
| Been treated for an eating disorder | | | | | |

**Drug, Food Supplements and Miscellaneous Agents**

Do you take any of the following?

| | Never | Rarely | Occasionally | Frequently |
|---|---|---|---|---|
| Diet Pills | | | | |
| Sleeping Pills | | | | |
| Laxatives | | | | |
| Antihistamines | | | | |
| Anti-Inflammatories | | | | |
| Tobacco | | | | |
| Birth Control Medications | | | | |
| Weight Gain Supplements | | | | |
| Over the Counter Medications | | | | |

List Any Prescription Medications Taken

_____

Do you currently have any of the following symptoms or problems?

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Frequent Headaches | | | Abdominal Pain | | |
| Visual Changes | | | Muscle Cramps | | |
| Ringing in Ears | | | Frequent Nausea | | |
| Sore Throats | | | Frequent Vomiting | | |
| Sinus Congestions | | | Frequent Diarrhea | | |
| Breathing Difficulty | | | Rectal Bleeding | | |
| Recurring Coughing | | | Unusual Fatigue | | |
| Chest Pain | | | Trouble Sleeping | | |

**General Medical Health History (continued)**

**Internal**

Were you born with a complete and functional set of paired organs? (Eyes, ears, kidneys, ovaries/testicles, lungs): (Check) Yes_____ No_____; If not, which organs were involved?

_____

_____

Have you ever had surgery to repair or remove any organ? (Hernia, tonsils, appendix, spleen, etc):

_____Yes _____No

1.) If yes, which organ? _____ (Check) Repaired_____ or Removed_____ Date: _____ Physician: _____ Physician's Address_____

2.) If yes, which organ? _____ (Check) Repaired_____or Removed_____

Date:_____ Physician:_____ Physician's Address_____

**Cardiac**

| | Yes | No |
|---|---|---|
| Have you ever felt dizzy, light-headed or passed out during or after exercise? | | |
| Have you ever had chest pain while exercising? | | |
| Have you ever had irregular heart beats or heart palpitations? | | |
| Have you been told you have a heart murmur? | | |
| Have you ever been seen by a heart specialist (cardiologist)?<br>If yes, Who:_____ Date:_____ | | |
| Have you ever had an echocardiogram? | | |
| Have you ever had a stress (heart) exam? | | |

**Vision**

Have you ever been to an eye doctor? _____Yes _____No

Date of Last Visit: _____ Physician's Name: _____

Phone #: _____ Address: _____

Do you wear Glasses now? ____ Yes _____No

Do you wear Contact lenses? ____ Yes _____No

Have you ever had an eye injury? ____Yes _____No Date of Incident: _____

Explain: _____

_____

Is your color vision normal? _____Yes _____No

**Orthopaedic History Questionnaire**

**Please Place a Check in Either the "Yes" or "No" Box**

**If you have any questions or uncertainties, please ask any medical personnel for assistance.**

**Have you ever Injured or Consulted a Doctor About an Injury to The…**

| HEAD/CONCUSSION | Yes | No | Date | Comments |
|---|---|---|---|---|
| Unconscious | | | | |
| Dazed/Dizzy | | | | |
| Knocked Out | | | | |
| Concussion #1 | | | | |
| Concussion #2 | | | | |
| Concussion #3 | | | | |
| Fractures | | | | |
| X-rays, CT, MRI | | | | |
| ** Previous baseline neuro-psych test? | | | | ***If yes, give name of test: Axon, Impact, Headminder*** |

| NECK | Yes | No | Date | Comments |
|---|---|---|---|---|
| Sprain/Strain | | | | |
| Stretches | | | | |
| Pinches | | | | |
| Disk Injury | | | | |
| Burners/Stingers | | | | |
| Injections | | | | |
| Pains | | | | |
| Fractures | | | | |
| X-rays, CT, MRI | | | | |
| Surgery | | | | |
| Other | | | | |

| Chest Wall | Yes | No | Date | Comments |
|---|---|---|---|---|
| Fractured Clavicle | | | | |
| Fractured Ribs | | | | |
| Sterno-clavicular Joint Separation | | | | |
| X-Rays, CT, MRI | | | | |
| Surgery | | | | |
| Other | | | | |

| Lower Back | Yes | No | Date | Comments |
|---|---|---|---|---|
| Sprain/Strain | | | | |
| Nerve Pinches | | | | |
| Disk Injury | | | | |
| Referred Pain | | | | |
| Pain Down leg | | | | |
| Numbness in Leg | | | | |
| Weakness in Leg | | | | |
| Fractures | | | | |
| X-rays, CT, MRI | | | | |
| Surgery | | | | |
| Other | | | | |

| Pelvis/Hips | Yes | No | Date | Comments |
|---|---|---|---|---|
| Sprain/Strain | | | | |
| Groin Pulls (specific) | | | | |
| Torn Muscles | | | | |
| Dislocations | | | | |
| Fractures | | | | |
| X-rays, CT, MRI | | | | |
| Surgery | | | | |
| Other | | | | |

| Thighs | Yes | No | Date | Comments |
|---|---|---|---|---|
| Quad strain | | | | |
| Hamstring strain | | | | |
| Calcium Deposits | | | | |
| Injections | | | | |
| Fractures | | | | |
| X-rays, CT, MRI | | | | |
| Surgery | | | | |
| Other | | | | |

| Knees | Yes | No | Date | Comments |
|---|---|---|---|---|
| Ligament Sprain(specific) | | | | |
| Patella Injury | | | | |
| Osgood Schlatter's | | | | |
| Bursitis | | | | |
| Swelling | | | | |
| Locking | | | | |
| Giving Away | | | | |
| Wear Braces | | | | |
| Arthritis | | | | |
| Chrondromalacia | | | | |
| Grinding/ Clicking | | | | |
| Tendonitis | | | | |
| Pain w/stairs | | | | |
| Pain w/squats | | | | |
| X-Rays/CT, MRI | | | | |
| Surgery | | | | |
| Other | | | | |

| Lower Legs | Yes | No | Date | Comments |
|---|---|---|---|---|
| Strain | | | | |
| Shin Splints | | | | |
| Torn Muscles | | | | |
| Injections | | | | |
| Achilles Tendon Pain | | | | |
| Stress Fractures | | | | |
| Fractures | | | | |
| X-Rays, CT, MRI | | | | |
| Surgery | | | | |
| Other | | | | |

| Ankles | Yes | No | Date | Comments |
|---|---|---|---|---|
| Sprain | | | | |
| Dislocation | | | | |
| Instability | | | | |
| Fractures | | | | |
| X-Rays, CT, MRI | | | | |
| Surgery | | | | |
| Other | | | | |

| Feet/Toes | Yes | No | Date | Comments |
|---|---|---|---|---|
| Sprains | | | | |
| Turf Toe | | | | |
| Dislocations | | | | |
| Injections | | | | |
| Fractures | | | | |
| X-Rays, CT, MRI | | | | |
| Surgery | | | | |
| Other | | | | |

| Shoulders | Yes | No | Date | Comments |
|---|---|---|---|---|
| Sprain/Strain | | | | |
| AC Separations | | | | |
| Dislocations | | | | |
| Partial Dislocations/ Subluxation | | | | |
| Tendonitis | | | | |
| Bursitis | | | | |
| Pain w/ overhead activities | | | | |
| Arm Goes "Dead" After Trauma | | | | |
| Fractures | | | | |
| X-rays, CT, MRI | | | | |
| Surgery | | | | |
| Other | | | | |

| Upper Arms/ Forearms | Yes | No | Date | Comments |
|---|---|---|---|---|
| Strain | | | | |
| Calcium Deposit | | | | |
| Casted | | | | |
| Injections | | | | |
| Numbness in Fingers | | | | |
| Fractures | | | | |
| X-rays, CT, MRI | | | | |
| Surgery | | | | |
| Other | | | | |

| Elbows | Yes | No | Date | Comments |
|---|---|---|---|---|
| Sprain/Strain | | | | |
| Bursitis | | | | |
| Dislocations | | | | |
| Joint Locking | | | | |
| Tendonitis | | | | |
| Fractures | | | | |
| X-Rays, CT, MRI | | | | |
| Surgery | | | | |
| Other | | | | |

| Wrists | Yes | No | Date | Comments |
|---|---|---|---|---|
| Sprain/Strain | | | | |
| Tendonitis | | | | |
| Dislocations | | | | |
| Casted | | | | |
| Fractures | | | | |
| X-rays, CT, MRI | | | | |
| Surgery | | | | |
| Other | | | | |

| Hands/Fingers | Yes | No | Date | Comments |
|---|---|---|---|---|
| Dislocations | | | | |
| Fractures | | | | |
| Surgery | | | | |
| Other | | | | |

| | Yes | No |
|---|---|---|
| Have you had or do have now any medical problems or injuries not listed on this form? | | |
| Do you have any medical or health problems that you are currently receiving medical treatment for? | | |
| Is there any reason that you are not able to participate in athletics? | | |
| Are there any additional health problems you would prefer to discuss privately with our team physician? | | |

If any of the first three questions above were answered with "Yes", please explain below:

_____
_____
_____
_____
_____
_____

List any special protective equipment you require or would like to have provided:

_____
_____

The undersigned, herewith,

A. Understands that he/she must refrain from practice or play during medical treatment until he/she is discharged from treatment or given a written permit by the attending physician to resume participation;
**B.** Certifies that the answers to these questions are correct and true;
**C.** Understands that his/her having passed the physician examination does not necessarily mean that he/she is physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify him/her; and
**D.** Fully realizes that the Clemson Athletic Department cannot be held responsible for any previous medical condition(s) that he/she might have.

Signature_____ Date_____

Upon completion of this History Form, it is to be reviewed and signed by a Staff Trainer.

Signature_____ A.T.,C Date_____

## Please Read the Following Consent Forms Carefully:

**(If you are under 18 years of age, your parents must also sign)**

The basis content of each is:

A. Medical Consent: Allows Clemson Athletic Department athletic trainers and physicians to treat any injury you receive while at Clemson University.

B. Shared Responsibility for Sports Safety: Acknowledges you that there are certain inherent risks involved in participating in intercollegiate athletics and that you are willing to assume responsibility for such risks..

C. Authorization Form: For Uses and Disclosures of Patient Protected Health Information

If you should choose to refuse to sign any of these, please write" Refused to Sign", date and your signature.

**Part A - Medical Consent**

I hereby grant permission to the Clemson University team physicians and/or their consulting physician to render to my son or daughter or myself, any treatment or medical or surgical care that they deem reasonably necessary to the health and well-being of the athlete.

I also hereby authorize the athletic trainers at Clemson University who are under the direction and guidance of the Clemson University team physicians , to render to my son or daughter or myself, any preventive, first aid, rehabilitation or emergency treatment that they deem reasonably necessary to the health and well- being of the athlete.

Also, when necessary for executing such case, I grant permission for hospitalization at an accredited hospital.

**Date:_____** _____

**Signature**

**Signature may be that of an athlete over 18 years of age; if under 18, please have it signed by parent or guardian.** _____

**Social Security Number**

_____

**Parent or Guardian**

**Part B - Shared Responsibility For Sports Safety**

Participation in sports requires an acceptance of risk of injury or even death. Athletes rightfully assume that those who are responsible for the conduct of sport have taken reasonable precaution to minimize such risk and that their peers participating in the sport will not intentionally inflict injury upon them.

**I have read the above shared responsibility statement. I understand that there are certain inherent risks involved in participating in intercollegiate athletics. I acknowledge the fact that these risks exist and I am willing to assume responsibility for such risks while participating at Clemson University. I also understand that it is my responsibility to report all injuries / illnesses to the Sports Medicine Dept. of Clemson University. This includes any concussion type symptoms.**

_____ _____

**Date** **Signature**

**Signature may be that of an athlete over 18 years of age; if under 18, please have it signed by parent or guardian.** _____

**Social Security Number**

_____

**Parent or Guardian**

**Part C - Authorization Form**

For Uses and Disclosures of Patient Protected Health Information

STUDENT ATHLETE:_____SPORT:_____

SOCIAL SECURITY NUMBER:_____ DATE OF BIRTH:_____

I hereby authorize Clemson University Athletic Department Athletics to release my protected health information. Protected health information may include:

I. injury or illness relevant to past, present or future participation in intercollegiate athletics at Clemson University

II. information contained in my personal medical record unrelated to my participation in intercollegiate athletics at Clemson University

III. information concerning my medical status, medical condition, injuries, prognosis, diagnosis and other related personally identifiable health information, including injury reports, test results, x-rays, progress reports and any other documentation regarding my health status

Authorization is granted for release of my protected health information to:

- the media, including specifically the Clemson University Sports Information Office, to advise the print, radio, television and other media of the nature, diagnosis, prognosis or treatment concerning my medical condition and any injuries or illnesses for the purpose of reporting it while I am a student-athlete
- professional athletic teams, professional sports scouting agencies, athletic trainers, physicians, servants or employees for the purpose of making decisions regarding my prospect as a professional athlete
- my parents/guardian and/or spouse for the purpose of assisting me in making healthcare decisions while I am a student-athlete
- the coaches, assistant coaches, and other athletic staff so that they may make decisions regarding my athletic ability and suitability to compete while I am a student-athlete
- my teammates so that they may be aware of limitations that I may be under while I am a student-athlete
- the student athletic trainers and other students who are participating in the provision of sports medicine healthcare to assist and participate in the provision of healthcare to me while I am a student-athlete
- amateur athletic organizations for the purpose of making decisions regarding my prospect as an athletic participant
- academic departments including the Student Athlete Enrichment Center (Vickery Hall) for the purpose of making decisions regarding my ability and suitability to perform academically while I am a student-athlete
- the Atlantic Coast Conference and National Collegiate Athletic Association for the purpose of making determination regarding my eligibility status while I am a student-athlete
- applicable medical, dental, and insurance providers for the purpose of processing insurance claims while I am a student-athlete
- the NCAA National Injury Tracking / Surveillance System for tracking injuries across the nation.

This authorization will automatically expire six years from the date it is signed

Please Note the Following:

You may refuse to sign this authorization. Your refusal will not affect you ability to obtain treatment or payment.

1. If the persons or entities who are authorized to receive the information above are not health care providers or health plans covered by federal health privacy laws, they may re-disclose the information and those laws would no longer protect the disclosed health information.

2. Once you sign this authorization, we can rely on it until you revoke it or, if you have not revoked it, until it expires. Any revocation will not be effective as to information already disclosed in reliance on the authorization. You can revoke this authorization by delivering a dated and signed letter to the Head Athletic Trainer addressed to:

   Danny Poole, ATC
   Head Athletic Trainer
   Clemson University
   P. O. Box 31
   Clemson, SC 29633

3. The information authorized for release may include records which indicate the presence of a communicable or venereal disease including, but not limited to, hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome ("AIDS") and/or mental health information.
4. Clemson University will not receive compensation for its use or disclosure of your protected health information.

_____
Printed name of Student-Athlete

Signature:_____ Date:_____
**Student Athlete or Legal Representative**

Capacity of * Legal Representative (if applicable):_____

*May be requested to provide verification of representative status