



TRYOUT CLEARANCE

The University of Texas at San Antonio

Student's Name: _____ Sport: _____

Student's UTSA ID#: _____

Initial Full-Time Enrollment at UTSA: ___/___/___ Initial Full-Time Enrollment: ___/___/___

I certify that I am a full-time student at the University of Texas at San Antonio and that to the best of my knowledge I am in good health and physically fit for practice and competition. I agree to comply will all of the rules and regulations of this university, C-USA and the NCAA. I understand that I will not be allowed to practice until I have been approved by each office in the clearance process.

Student's Signature: _____ Date: _____

| | |
|--|--|
| Step 1- Receive the signature of the coach | |
| I agree to allow this student to practice but not compete until a determination of eligibility is made. | |
| Coach's Signature: _____ Date: _____ | |
| Step 2- Receive the signature of the Academic Office | Number of Credits |
| The student is enrolled as a full-time student at UTSA. | <div style="border: 1px solid black; width: 60px; height: 40px; margin: 0 auto;"></div> |
| Academic Office Signature: _____ | |
| Step 3- Obtain approval from the training room staff | |
| The student has passed a medical exam and has signed the Medical History and Consent Waiver | |
| Trainer's Signature: _____ Date: _____ | |
| Step 4- Review of outside aid (JPL 1.01.03) | Date of financial registration: ___/___/___ |
| The student does not have any outside aid or, if student does have outside aid, the student is not recruited and aid does not exceed the individual full grant-in-aid limit. | |
| Financial Aid Signature: _____ Date: _____ | |
| Step 5- Receive final approval from the Compliance Office (MS 1.02.66) | |
| This student has met the necessary requirements and has been approved to practice. | |
| This student is a transfer student. _____ This student is a freshman. _____ This student is a continuing student. _____ Was this student recruited by UTSA? <input type="checkbox"/> Yes <input type="checkbox"/> No | ** FOR ALL STUDENTS ** Registered with the Eligibility Center? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the student's initial eligibility status? <input type="checkbox"/> Qualifier <input type="checkbox"/> Non-Qualifier <input type="checkbox"/> Pending What is this student's amateurism status? <input type="checkbox"/> Final Certified <input type="checkbox"/> Pending <input type="checkbox"/> Must request final Previously tried out for a sport at <u>any</u> school? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Compliance Office Signature: _____ Date: _____ | |

2013-2014

REQUIRED FORMS FOR TRYOUTS

Please ensure the forms listed below have been completed and the information provided is accurate. Any missing information will delay medical clearance. Student-athletes will not be eligible to participate in intercollegiate athletics until all information is received. Please return this information immediately. These items must be received before your scheduled physical exam.

- Student Acknowledgement Form- Pg. 2
- Health Insurance Form- Pg. 3
- Front and back copy of current health insurance card- Pg. 4
- Emergency Contact Form- Pg. 5
- Medical History Questionnaire- Pg. MH 1-9
- Physical Exam
- Sickle Cell Trait test results
- Medical records for any previous injuries or illnesses

Student-athletes who do not complete this task will **not be eligible to participate** in intercollegiate athletics until the completed forms are received and reviewed by the UTSA Athletic Training Staff.

To be completed by student-athlete or parent/guardian if under the age of 18.

I have completed all UTSA Sports Medicine forms accurately. I have included any medical records pertaining to any significant injuries or illnesses I have experienced. I understand that the UTSA Sports Medicine Staff may ask for additional medical records and/or information pertaining to insurance or medical history and that failure to provide requested documents may delay participation in intercollegiate athletics.

Student-Athlete Signature

DATE

Parent/Guardian Signature (If athlete is a minor)

DATE

SPORTS MEDICINE
2013-2014
TRYOUTS ONLY
IMPORTANT INFORMATION - READ
CAREFULLY!!

***ANY STUDENT WISHING TO TRYOUT FOR AN ATHLETIC TEAM
MUST READ AND ACKNOWLEDGE THE INFORMATION BELOW***

Preparticipation Physical Exam

Any student who plans to try out for an athletic team must obtain a physical examination by a licensed physician. **We will not accept a physical signed by a nurse practitioner, physician assistant, chiropractor, nurse, or any other healthcare provider that is not a licensed physician. Only the UTSA medical history and physical forms can be used and must be returned to the sports medicine staff prior to the tryout.** The UTSA sports medicine staff and team physicians have the right to request additional medical information and testing prior to medical clearance.

Sickle Cell Trait Testing

All tryouts must obtain a sickle cell trait test and provide the sports medicine staff with the results prior to the scheduled tryout. If results from testing at birth are not available, the test should be done by a family physician or the physician doing the pre-participation physical exam. In the event a tryout cannot obtain testing, the sports medicine staff can arrange for the test to be completed at Student Health Services. Testing at Student Health Services should be facilitated by the sports medicine staff and the student will be responsible for payment for this test. Keep in mind results typically take 48 hours so this should be done well in advance of the scheduled tryout.

Health Insurance

All tryouts must provide insurance information on the appropriate forms. In the event that a tryout becomes an active member of the roster, he/she must maintain insurance coverage and notify the sports medicine staff immediately in the case there is a change in coverage. **ALL TRYOUTS MUST SHOW PROOF OF PRIMARY HEALTH INSURANCE THAT COVERS ATHLETIC RELATED INJURIES.** This is required for medical clearance. UTSA provides secondary insurance coverage for injuries that occur as a result of participation in intercollegiate athletics only during the respective season. Claims must be filed on primary insurance before the secondary insurance considers the claim. For more information on health insurance, please contact the UTSA Sports Medicine Staff.

Emergency Contact Information

All TRYOUTS must complete the "Emergency Contact Form" as part of the medical clearance process.

*All required forms are in this packet. If you have any questions, please contact the UTSA Athletic Training Room at (210) 458-4178 or (210) 458-6918. Additional forms and information will be presented at team meetings.

Please initial that you acknowledge and agree to the information provided. _____

UTSA SPORTS MEDICINE
Health Insurance Form
2013-2014

(Please type or print legibly and complete all requested information)

STUDENT-ATHLETE INFORMATION

Name: _____ Sport: _____
Banner ID: _____ Date of Birth: _____
MM/DD/YYYY
Email: _____

INSURANCE INFORMATION

Insurance Company: _____ Telephone: (____) _____
Claims Mailing Address: _____
City: _____ State: _____ Zip: _____
Name of Policy Holder: _____
Policy Holders Date of Birth: _____
Policy or ID #: _____ Group #: _____
Effective Date: From _____ to _____ Deductible: \$ _____
MM/DD/YYYY MM/DD/YYYY

Please check the appropriate box.

This policy is a: ___ PPO ___ POS ___ HMO ___ Other: _____

Are there any restrictions to this insurance policy?

- NO
 YES - If you answer yes, please explain:

Is the above student-athlete covered under a Dental Policy? ___ Yes ___ No

If you answered yes, please include a front and back copy of the dental insurance card if it is different from your health insurance card.

Is the above student-athlete covered under an eye care policy? ___ Yes ___ No

If you answered yes, please include a front and back copy of the eye card card if it is different from your health insurance card.

Is the above student-athlete covered under a drug prescription plan? ___ Yes ___ No

If you answered yes, please include a front and back copy of the prescription card if it is different from your health insurance card.

I certify that the above insurance information to my knowledge is accurate and up-to-date. Should there be any changes in regards to the status of my health insurance I will notify the UTSA athletic training department immediately.

Signature of Policy Holder

Date

**UTSA SPORTS MEDICINE
HEALTH INSURANCE CARD
2013-2014**

[Attach photocopy of front of insurance card here]

[Attach photocopy of back of insurance card here]

To be completed by student-athlete or parent/guardian if the student-athlete is a minor.

I certify the attached insurance card is current and reflects the insurance coverage I have at the present time. If at anytime my insurance coverage changes, I will notify the UTSA Sports Medicine Staff of the change and provide the most current insurance coverage immediately.

Student-Athletic Signature

DATE

Parent/Guardian Signature (if student-athlete is a minor)

DATE

UTSA SPORTS MEDICINE
Student Athlete Emergency Contact Form
2013-2014

(Please type or print legibly and complete all requested information)

STUDENT-ATHLETE INFORMATION:

Name: _____ Sport: _____

Date of Birth: _____ Banner ID: _____
MM/DD/YYYY

Email: _____

Address While Attending UTSA: _____

City: _____ State: _____ Zip: _____

Student-Athletes Local/Cell Phone: (_____) _____

Name of Parent/Guardian: _____

Permanent Address: _____

City: _____ State: _____ Zip: _____

Parents/Guardian Phone: (_____) _____

EMERGENCY CONTACT INFORMATION:

Primary Contact Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Work Phone: (_____) _____ Email: _____:

****For your secondary emergency contact, please list someone other than a coach, Teammate or parent/guardian.**

Secondary Contact Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Work Phone: (_____) _____

NAME: _____
 SPORT: _____

2013-2014 UTSA General Medical Physical Examination

| | |
|---|--|
| VITAL SIGNS | |
| Height _____ Weight _____ BMI ____ Pulse ____ BP ____/____ (____/____, ____/____) | |
| Vision R20 / ____ L20 / ____ Corrected: Y or N / Pupils: Equal ____ Unequal ____ | |

To Be Completed By Medical Personnel:

| | Normal | Findings | Initials* |
|----------------------------|--------|----------|-----------|
| MEDICAL | | | |
| Appearance | | | |
| Eyes/ears/nose/throat | | | |
| Hearing | | | |
| Lymph nodes | | | |
| Heart | | | |
| Murmurs | | | |
| Pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitourinary (males only) | | | |
| Skin | | | |
| Neurological | | | |

Notes/Referrals/Special Tests: _____

Physician Clearance

I certify that I have examined this student on this date and that, based on the examination required by UTSA and the student's medical history as furnished to me, this student is **cleared to participate with:**

- Cleared to participate in full competition**
- Cleared to participate with restrictions** (please explain)
- Not cleared for participation** (please explain)

This form can be signed by a licensed Medical Physician or licensed Osteopath only.

Explanation _____

Examiner's Signature: _____ Date: _____

Physician Please Print Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

NAME: _____
SPORT: _____

2013-2014 UTSA Orthopedic Physical Examination

To Be Completed By Medical Personnel:

| | Normal | Findings | Initials* |
|------------------------|---------------|-----------------|------------------|
| MUSCULOSKELETAL | | | |
| Neck | | | |
| Back | | | |
| Shoulder/arm | | | |
| Elbow/forearm | | | |
| Wrist/hand/fingers | | | |
| Hip/thigh | | | |
| Knee | | | |
| Leg/ankle | | | |
| Foot/toes | | | |

*Multiple-examiner set-up only.

Notes/Referrals/Special Tests: _____

To Be Completed By Medical Personnel:

Physician Clearance

I certify that I have examined this student on this date and that, based on the examination required by UTSA and the student's medical history as furnished to me, this student is **cleared to participate with:**

- Cleared to participate in full competition**
- Cleared to participate with restrictions** (please explain)
- Not cleared for participation** (please explain)

This form can be signed by a licensed Medical Physician or licensed Osteopath only.

Explanation _____

Examiner's Signature: _____ Date: _____

Physician Please Print Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone Number: _____



UTSA Department of Intercollegiate Athletics
Health and Medical History Questionnaire – TRYOUTS ONLY
2013-2014

Name: _____ Sport: _____

DOB: ___/___/____ Grade (circle one): FR SO JR SR 5th

Banner ID: _____

Please print legibly. Please provide accurate information and complete all sections.

MEDICATION

Please list **ALL** prescription and over-the-counter medication you are currently taking and have taken in the last two years. Please indicate the dosage and reason for the medication, as well as the dates. (If you need additional space, please attach a separate piece of paper.)

| <u>MEDICATION</u> | <u>PURPOSE</u> | <u>DOSAGE</u> | <u>DATES</u> |
|-------------------|----------------|---------------|--------------|
| _____ | | | |
| _____ | | | |
| _____ | | | |

Have you ever been diagnosed with ADD (Attention Deficit Disorder) or ADHD (Attention Deficit and Hyperactivity Disorder)?

YES NO

Are you currently taking medication for ADD (Attention Deficit Disorder) or ADHD (Attention Deficit and Hyperactivity Disorder)?

YES NO

If yes, please list the medication _____

- ❖ Effective August 2009 there will be a stricter application of the NCAA Medical Exception Policy, specifically for the use of banned stimulant medication to treat Attention Deficit Hyperactivity Disorder (ADHD). This stricter application will require documentation that demonstrates the student athlete has undergone a clinical assessment to diagnose ADHD, is being monitored routinely for use of the stimulant medication, and has a current prescription on file, in order to be approved for a medical exception to the banned drug policy. This documentation should be kept on file at the institution and produced in the event the student-athlete tests positive for the banned medication. Student athletes who are currently taking a banned stimulant for the treatment of ADHD must provide this documentation before they will be cleared to participate in intercollegiate athletics at UTSA. Furthermore, student athletes who do not disclose to the athletic training staff that they are taking a banned substance could potentially face loss of eligibility in the event of a positive NCAA drug test.

Cardiovascular/Heart

| | | |
|--|-----|----|
| Have you ever experienced any of the following during or after exercise, a practice, or a game?: | | |
| Chest pain or pressure | YES | NO |
| Dizziness or light headedness | YES | NO |
| Fainting or passing out | YES | NO |
| Racing heart | YES | NO |
| Skipping or irregular heart beats | YES | NO |
| | | |
| Do you fatigue or get tired quicker than your teammates and friends during exercise or practice? | YES | NO |
| Have you ever been told you have a heart murmur? | YES | NO |
| Has a family member or relative died of heart problems or sudden death before the age of 50? | YES | NO |
| Has a physician ever denied or restricted you from playing sports due to heart or cardiovascular problem or family history? | YES | NO |
| Have you ever been examined by a cardiologist? | YES | NO |
| Have you ever had an electrocardiogram (EKG)? | YES | NO |
| Have you ever had an echocardiogram (ECHO)? | YES | NO |
| Does anyone in your family have high blood pressure? | YES | NO |
| Does anyone in your family have high blood cholesterol? | YES | NO |
| Have you ever been told you have/had high blood pressure? | YES | NO |
| Have you ever been told you have/had high cholesterol? | YES | NO |
| Have you or any family member ever been diagnosed with enlarged heart, hypertrophic cardiomyopathy, Long QT syndrome, Marfan's syndrome, or abnormal heart rhythm? | YES | NO |

If you answered **YES** to any of the above questions, please explain

Head Injuries/Concussion

| | | |
|--|-----|----|
| Have you ever suffered a head injury/concussion (no matter how minor)? | YES | NO |
| Have you ever been evaluated by a doctor for a head injury/concussion? | YES | NO |
| Have you ever had any of the following tests performed on your head/brain?: | | |
| XRAY | YES | NO |
| MRI | YES | NO |
| CT Scan | YES | NO |
| Neuropsychological tests | YES | NO |
| Other _____ | YES | NO |
| | | |
| Have you ever been hospitalized, knocked out, become unconscious, and/or lost your memory due to getting hit in the head/concussion/head injury? | YES | NO |
| Have you been advised not to participate in athletic activities due to a head injury/concussion? | YES | NO |
| If yes, how long did you refrain from activity? _____ | | |
| Have you experienced headaches for more than three months? | YES | NO |
| If you answered <u>YES</u> to any of the above, please explain and provide dates | | |

| | | |
|--|-----|----|
| Do you suffer from headaches? | YES | NO |
| If yes, when? (circle one) | | |
| EVERYDAY 1-2 TIMES A WEEK 1-2 TIMES A MONTH OTHER _____ | | |
| | | |
| Do you suffer from migraines? | YES | NO |
| How often? _____ | | |
| | | |
| Migraine Medication? (please list) _____ | | |

Asthma

| | | |
|--|-----|----|
| Have you ever been diagnosed with asthma and/or exercise induced asthma? | YES | NO |
| Are you presently taking or have taken in the past any asthma medications? | YES | NO |
| Have you ever been hospitalized as a result of asthma and/or exercised induced asthma? | YES | NO |
| Have you ever been advised not to participate in athletic activities due to asthma? | YES | NO |
| Does anyone in your family suffer from asthma? | YES | NO |
| Do you currently have trouble breathing during exercise or practice? | YES | NO |

If you answered **YES** to any of the above, please explain and list all asthma medications.

ASTHMA SUFFERERS ONLY:

How many times do you use your rescue inhaler during an average week? _____

How many asthma attacks have you had in the last month? _____

Allergies

| | | |
|--|-----|----|
| Do you have any allergies to medications? | YES | NO |
| Do you have any allergies to foods? | YES | NO |
| Do you have any allergies to insect bites, bee stings, etc.? | YES | NO |

If you answered **YES** to any of the above, please list all allergies.

| | | |
|--|-----|----|
| Have you been diagnosed with seasonal allergies? | YES | NO |
| Are you currently taking/have you previously taken allergy medication? | YES | NO |

If you answered **YES**, please list all allergy medication you are currently taken or have taken.

Sickle Cell Anemia/Sickle Cell Trait

| | | |
|---|-----|----|
| Have you ever been told you have Sickle Cell Trait? | YES | NO |
|---|-----|----|

If **YES**, do you regularly experience any of the following symptoms during or after exercise?:

| | | |
|----------------------|-----|----|
| MUSCLE CRAMPING | YES | NO |
| FATIGUE | YES | NO |
| DEHYDRATION | YES | NO |
| FAINTING/PASSING OUT | YES | NO |

| | | |
|--|-----|----|
| Does anyone in your family have sickle cell trait? | YES | NO |
| Do you or anyone in your family have sickle cell anemia? | YES | NO |

If **YES** to any of the above, please explain:

Heat Related Injury and Illness

| | | |
|--|-----|----|
| Have you ever suffered from heat cramps? | YES | NO |
| Have you ever fainted from exercising in the heat? | YES | NO |
| Have you ever suffered from heat exhaustion? | YES | NO |
| Have you ever suffered from heat stroke? | YES | NO |
| Have you ever received IV fluids for a heat related injury or illness? | YES | NO |
| Have you ever been hospitalized for a heat related injury or illness? | YES | NO |

If you answered **YES** to any of the above, please explain and provide dates.

Communicable Diseases

Have you ever been diagnosed with a communicable disease (MRSA/Staph infection, Sexually Transmitted Disease, HIV, Hepatitis, Herpes, Syphilis, Tuberculosis, meningitis, etc.)? YES NO
If **YES**, please list and provide dates.

Eyes

Do you wear glasses? YES NO
Do you wear contact lenses? YES NO
When was your last eye exam? _____
Have you ever suffered an injury to your eye(s)? YES NO
If **YES**, please explain and provide dates.

Have ever been diagnosed with an eye disease? YES NO
If **YES**, please explain and provide dates.

Do you regularly suffer from blurred vision, double vision, tunnel vision, and/or other abnormal vision? YES NO
If **YES**, please explain.

Ear/Nose/Throat

Do you have frequent ear infections? YES NO
Do you have difficulty hearing? YES NO
Do you have ringing in your ears? YES NO
Do you have frequent nosebleeds? YES NO
Do you frequently suffer from a sore throat? YES NO
If **YES**, please explain.

Have you had strep throat or tonsillitis in the last 12 months? YES NO
If **YES**, please list how many infections you have had in the last 12 months. _____

Have you been told you should have your tonsils removed? YES NO
If **YES**, please explain. _____

Dental

When was your last dental exam? _____
Were there any significant findings from your last dental exam? YES NO
Have you ever suffered an injury to your mouth, jaw, tooth, or teeth? YES NO
If **YES**, please explain and provide dates.

Do you wear a mouth guard while playing sports? YES NO

Dermatological

| | | |
|---|-----|----|
| Have you experienced any skin problems (rashes, acne, warts, eczema, fungus, etc.)? | YES | NO |
| Have you ever experienced a rash or hives during or after exercise? | YES | NO |
| Have you ever been under the care of a dermatologist for any condition? | YES | NO |
| If YES , please explain and provide dates. | | |

Abdomen

| | | |
|---|-----|----|
| Do you regularly experience abdominal or stomach pain? | YES | NO |
| If yes, please explain: _____ | | |
| Have you ever been diagnosed with a problem affecting your stomach, abdomen, intestines, or rectum? | YES | NO |
| If yes, please explain: _____ | | |
| Have you had any diagnostic testing on your abdomen? | YES | NO |
| Please circle all that apply: XRAY MRI CT SCAN ENDOSCOPY COLONOSCOPY OTHER _____ | | |
| Have you ever had any kind of abdominal surgery? | YES | NO |
| If yes, please explain: _____ | | |
| Do you regularly experience chronic or recurrent diarrhea? | YES | NO |
| Have you ever been diagnosed with a stomach ulcer? | YES | NO |
| Have you ever been diagnosed with gall bladder disease or gall stones? | YES | NO |
| Do you regularly experience urinary tract infections or other urinary problem? | YES | NO |
| If yes, how many in the last 12 months: _____ | | |
| Have you been diagnosed with kidney disease, or other kidney problem? | YES | NO |
| If yes, please explain: _____ | | |
| Have you had an organ removed or are missing any organ (kidney, ovary, testicle, etc.)? | YES | NO |
| If yes, please explain: _____ | | |
| Have you ever suffered an injury to your abdomen? | YES | NO |
| If yes, please explain: _____ | | |
| Have you ever been advised not to participate in athletic activities due to an abdominal injury or condition? | YES | NO |

Additional Health Concerns

| | | |
|---|-----|----|
| Have you had any injury or illness other than those previously noted? | YES | NO |
| Do you have any ongoing or chronic illnesses? | YES | NO |
| Have you ever been hospitalized overnight? | YES | NO |
| Has a physician ever restricted you from athletic activities, practices, or other exercise for any reason? | YES | NO |
| Are you currently under a physician's care for any medical condition(s)? | YES | NO |
| Do you regularly consult with a holistic medicine practitioner or other non-physician practitioners? | YES | NO |
| Do you regularly see a chiropractor? | YES | NO |
| Are you happy with your weight? | YES | NO |
| Are you currently trying to gain or lose weight? | YES | NO |
| Have you experienced any recent weight loss or weight gain in the last 6 months? | YES | NO |
| Do you have any dietary restrictions (vegetarian-all types, gluten free, etc.)? | YES | NO |
| Have you ever been diagnosed with an eating disorder? | YES | NO |
| Have you had a viral infection (mononucleosis, myocarditis, etc.)? | YES | NO |
| Have you ever been told you are hypoglycemic, hyperglycemic, or diabetic? | YES | NO |
| Have you had a seizure, convulsions, or been diagnosed with epilepsy? | YES | NO |
| Have you suffered a traumatic injury or unexpected illness that was not sports-related, but required immediate medical attention? | YES | NO |
| Have you ever been restricted from playing sports for a month or more due to a non-orthopaedic injury or illness? | YES | NO |
| Do you currently have any health concerns you would like to discuss with a physician? | YES | NO |
| Please explain any YES answers here: | | |

Mental Health

Have you been under the care of a psychiatrist/psychologist in the last 5 years (including the present time)? YES NO
 Have you ever been diagnosed with depression, anxiety/panic disorder, or other mental health condition? YES NO
 Are you currently taking any medication for a mental health condition? YES NO
 Have you taken any medication for a mental health condition in the last 5 years? YES NO
 Have you ever been hospitalized due to a mental health condition? YES NO

Please explain any **YES** answers in detail here:

Supplements

Many supplement products contain NCAA-banned substances that are not always recognized as such or included in the supplement labels. Thus, student-athletes have tested positive for NCAA-banned substances by ingesting products they obtained in retail stores, gyms and over the Internet. In addition, the U.S. Food and Drug Administration does not strictly regulate the supplement industry; therefore, purity and safety of nutritional/dietary supplements cannot be guaranteed. Impure supplements may lead to a positive NCAA drug test. The use of supplements is at the student-athlete's own risk.

Please list any supplements you are currently taking here (please include brand name):

*UTSA encourages all student-athletes to check with their staff athletic trainer prior to purchasing and consuming any nutritional/dietary supplement. Please see your athletic trainer for any questions.

Women's Health (females only)

Date of your last pap smear? _____
 Have you ever had an abnormal pap smear? YES NO
 If **YES**, please provide additional details and findings:

Are you currently taking any form of birth control? (pill, patch, NuvaRing, etc.) YES NO
 Other than routine exams, are you currently under the care of an OB/GYN for an ongoing problem? YES NO
 If **YES**, please explain:

At what age did you begin menstruating? _____
 Date of your last menstrual period: _____
 How many periods have you had in the last 12 months? _____
 Do you frequently skip periods? YES NO
 If yes, what is the longest you have gone without having a period (in months)? _____
 Do you have heavy periods? YES NO
 How many days does your period last on average? _____
 Do you experience pain or severe cramping during your period? YES NO

Are you aware of any reason you should not participate in intercollegiate athletics at UTSA? YES NO
 If **yes**, please explain

Orthopaedic History

Name: _____

Sport: _____

Grade: FR SO JR SR 5TH

Cervical Spine/Neck

Have you ever suffered an injury to your cervical spine/neck? YES NO

Have you ever had any diagnostic tests performed on your c-spine/neck? YES NO

If yes, please circle all that apply: X-RAY MRI CT SCAN BONE SCAN OTHER _____

Have you ever had a "burner", "stinger", or other brachial plexus injury? YES NO

Have you ever experienced numbness' and/or tingling in your arms, hands, and/or fingers? YES

NO

Have you ever had surgery and/or an injection of any kind to your c-spine/neck? YES NO

Have you ever been advised not to participate in sports due to a c-spine/neck injury? YES NO

If **yes** to any of the above, please explain and provide dates.

Shoulder/Arm

Have you ever suffered an injury to your shoulder/upper arm? YES NO

Have you ever had any diagnostic tests performed on your shoulder/upper arm? YES NO

If yes, please circle all that apply: X-RAY MRI CT SCAN BONE SCAN OTHER _____

Have you ever had surgery and/or injection of any kind to your shoulder/upper arm? YES NO

Have you ever been advised not to participate in sports due to a shoulder/upper arm injury? YES NO

If **yes** to any of the above, please explain and provide dates.

Elbow/Forearm

Have you ever suffered an injury to your elbow/forearm? YES NO

Have you ever had any diagnostic tests performed on your elbow/forearm? YES NO

If yes, please circle all that apply: X-RAY MRI CT SCAN BONE SCAN OTHER _____

Have you ever had surgery and/or injection of any kind to your elbow/forearm? YES NO

Have you ever been advised not to participate in sports due to an elbow/forearm injury? YES NO

If **yes** to any of the above, please explain and provide dates.

Wrist/Hand/Fingers

Have you ever suffered an injury to your wrist(s), hand(s), and/or finger(s)? YES NO

Have you ever had any diagnostic tests performed on your wrist/hand/finger? YES NO

If yes, please circle all that apply: X-RAY MRI CT SCAN BONE SCAN OTHER _____

Have you ever had surgery and/or injection of any kind to your wrist/hand/fingers? YES NO

Have you ever been advised not to participate in sports due to a wrist/hand/finger injury? YES NO

If **yes** to any of the above, please explain and provide dates.

Spine/Low back/Sacroiliac (SI) joint

| | | |
|--|-----|----|
| Have you ever suffered an injury to your spine, low back, and/or SI joint? | YES | NO |
| Have you ever had any diagnostic tests performed on your spine, low back and/or SI joint? | YES | NO |
| If yes, please circle all that apply: X-RAY MRI CT SCAN BONE SCAN OTHER _____ | | |
| Have you ever had surgery and/or an injection of any kind to your spine/low back/SI joint? | YES | NO |
| Have you ever had numbness/tingling in one or both of your legs and/or feet? | YES | NO |
| Have you ever been advised not to participate in sports due to a spine/low back/SI joint injury? | YES | NO |
| If yes to any of the above, please explain and provide dates. | | |

Hip/Groin

| | | |
|--|-----|----|
| Have you ever suffered an injury to your hip/groin? | YES | NO |
| Have you ever had any diagnostic tests performed on your hip/groin? | YES | NO |
| If yes, please circle all that apply: X-RAY MRI CT SCAN BONE SCAN OTHER _____ | | |
| Have you ever had surgery and/or an injection of any kind on your hip/groin? | YES | NO |
| Have you ever been advised not to participate in sports due to a hip/groin injury? | YES | NO |
| If yes to any of the above, please explain and provide dates. | | |

Thigh/Hamstrings/Quadriceps

| | | |
|--|-----|----|
| Have you ever suffered an injury to your thigh/hamstrings/quadriceps? | YES | NO |
| Have you ever had any diagnostic tests performed on your thigh/hamstrings/quadriceps? | YES | NO |
| If yes, please circle all that apply: X-RAY MRI CT SCAN BONE SCAN OTHER _____ | | |
| Have you ever had surgery and/or an injection of any kind to your thigh/hamstrings/quadriceps? | YES | NO |
| Have you ever been advised not to participate in sports due to a thigh/hamstrings/quadriceps injury? | YES | NO |
| If yes to any of the above, please explain and provide dates. | | |

Knee/Patella

| | | |
|---|-----|----|
| Have you ever suffered an injury to your knee/patella? | YES | NO |
| Have you ever had any diagnostic tests performed on your thigh/hamstrings/quadriceps? | YES | NO |
| If yes, please circle all that apply: X-RAY MRI CT SCAN BONE SCAN OTHER _____ | | |
| Have you ever had surgery and/or injection of any kind to your knee/patella? | YES | NO |
| Have you ever been advised not to participate in sports due to a knee/patella injury? | YES | NO |
| Do you wear a knee brace? | YES | NO |
| If yes to any of the above, please explain and provide dates. | | |

Ankle/Lower Leg

| | | |
|---|-----|----|
| Have you ever suffered an injury to your ankle/lower leg? | YES | NO |
| Have you ever had any diagnostic tests performed on your ankle/lower leg? | YES | NO |
| If yes, please circle all that apply: X-RAY MRI CT SCAN BONE SCAN OTHER _____ | | |
| Have you ever had surgery and/or injection of any kind to your ankle/lower leg? | YES | NO |
| Have you ever been advised not to participate in sports due to an ankle/lower leg injury? | YES | NO |
| Do you presently tape your ankles regularly? | YES | NO |
| Do you presently wear ankle braces? | YES | NO |
| If yes to any of the above, please explain and provide dates. | | |

Foot/Toes

| | | |
|---|-----|----|
| Have you suffered an injury to your foot/toes? | YES | NO |
| Have you ever had any diagnostic tests performed on your foot/toes? | YES | NO |
| If yes, please circle all that apply: X-RAY MRI CT SCAN BONE SCAN OTHER _____ | | |
| Have you ever had surgery and/or an injection of any kind to your foot/toes? | YES | NO |
| Have you ever been advised not to participate in sports due to a foot/toe injury? | YES | NO |
| Do you currently wear orthotics? | YES | NO |

If **yes** to any of the above, please explain and provide dates.

Ribs/Thorax/Chest

| | | |
|--|-----|----|
| Have you ever suffered an injury to your ribs/thorax/chest? | YES | NO |
| Have you ever had any diagnostic tests performed on your ribs/thorax/chest? | YES | NO |
| If yes, please circle all that apply: X-RAY MRI CT SCAN BONE SCAN OTHER _____ | | |
| Have you ever had surgery and/or an injection of any kind to your ribs/thorax/chest? | YES | NO |
| Have you ever been advised not to participate in sports due to an injury to the ribs/thorax/chest? | YES | NO |

If **yes** to any of the above, please explain and provide dates.

Additional Orthopaedic Concerns

| | | |
|---|-----|----|
| Have you ever been withheld or restricted from participation in sports due to an orthopaedic injury, other than those listed previously? | YES | NO |
| Have you ever been restricted for a month or more from sports activity due to an orthopaedic injury? | YES | NO |
| Have you undergone surgery for an orthopaedic injury, other than those listed previously? | YES | NO |
| Have you suffered the same injury more than once? | YES | NO |
| Do you routinely suffer from over-use injuries that resolve with rest, and recur as you exercise more frequently and/or at a higher intensity? | YES | NO |
| Have you ever had a stress fracture anywhere in your body, not previously noted? | YES | NO |
| If yes, have you had any recurring stress fractures in the same body part? | | |
| Do you regularly wear any type of brace, sleeve, wrap, or support, other than those previously noted? | YES | NO |
| Have you ever suffered a traumatic orthopaedic injury as a result of an accident or other non-sports related activity, that required immediate medical attention? | YES | NO |
| Do you currently have any orthopaedic concerns you would like to discuss with a physician? | YES | NO |

Please explain any **yes** answers here and provide dates if possible.

I herby state that I have completed the medical history and provided correct and honest answers.

Athlete Name (please print) _____

Athlete Signature _____

Date _____

Parent/Guardian Name (if athlete is a minor) _____

Parent/Guardian Signature _____

Date _____