University of Iowa Sports Medicine

Medical History and Information Form

Hospital # _____ For office use only

Personal Information

Student-Athlete _____ Sport _____

Gender _____ Date of Birth _____

UI Student ID _____

Campus Address _____

City _____

State _____ ZIP Code _____

Cell Phone/Campus Phone _____

E-mail _____

Emergency Contact

Name _____

Relationship _____

Home Phone _____ Cell Phone _____

Work Phone _____ E-mail _____

Allergies/Intolerances

Please list and 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 of 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. The NCAA mandates disclosure of stimulant medication (this may include, but is not limited to Adderall, Ritalin, Concerta, etc).

Supplements

Please list ALL vitamins and supplements (this may include, but is not limited to, weight gain or weight loss supplements, hers, 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

Vaccinations

Last Tdap

MMR #1

MMR #2

Medical Information

Please list any surgical procedures you have had, including 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?

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 a ny 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 (include who and year of diagnosis occurrence)

Cancer	☐ Yes	☐ No	Specifics
High blood pressure/ Hypertension	☐ Yes	☐ No	Specifics
Sickle Cell Trait/ Disease	☐ Yes	☐ No	Specifics
Tuberculosis	☐ Yes	☐ No	Specifics
Diabetes	☐ Yes	☐ No	Specifics
Kidney Disease	☐ Yes	☐ No	Specifics
Heart Disease	☐ Yes	☐ No	Specifics
Marfan's Syndrome	☐ Yes	☐ No	Specifics
Cardiomyopathy	☐ Yes	☐ No	Specifics
Arthritis	☐ Yes	☐ No	Specifics

Hay Fever	☐ Yes	☐ No	Specifics	
Convulsive Disorders	☐ Yes	☐ No	Specifics	
Emotional Disorders	☐ Yes	☐ No	Specifics	
Alcohol Disorder	☐ Yes	☐ No	Specifics	
Died less than 50 years old	☐ Yes	☐ No	Specifics	

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			If YES, please comment	
Chest pain or discomfort during or after exercise	☐ Yes	☐ No	Comment	
Palpations or irregular heartbeat during or after exercise	☐ Yes	☐ No	Comment	
Have you ever passed out during or after exercise	☐ Yes	☐ No	Comment	
Have you ever been dizzy during or after exercise	☐ Yes	☐ No	Comment	
Do you get tired more quickly than your teammates during exercise	☐ Yes	☐ No	Comment	
Have you ever been told you have a heart murmur	☐ Yes	☐ No	Comment	
Has a physician ever denied or restricted participation in activity due to any heart problems	☐ Yes	☐ No	Comment	
Have you ever had high cholesterol	☐ Yes	☐ No	Comment	
Have you had myocarditis or mono in the last month	☐ Yes	☐ No	Comment	
Have you ever been knocked out, became unconscious or lost your memory	☐ Yes	☐ No	Comment	

Have you ever had a seizure	☐ Yes	☐ No	Comment	
Do you have frequent or severe headaches	☐ Yes	☐ No	Comment	
Numbness/tingling in arms, hands, legs, or feet	☐ Yes	☐ No	Comment	
Have you ever had a burner, stinger, or pinched nerve	☐ Yes	☐ No	Comment	
Have you ever become ill from exercising in the heat	☐ Yes	☐ No	Comment	
Restricted from participation due to heat illness	☐ Yes	☐ No	Comment	
Cramps during or after exercise	☐ Yes	☐ No	Comment	
Heat related illness (exhaustion, stroke)	☐ Yes	☐ No	Comment	
Cough, wheeze, or have difficulty breathing during or after exercise	☐ Yes	☐ No	Comment	
Do you have hay fever or seasonal allergies that require medical treatment	☐ Yes	☐ No	Comment	
Do you have any skin problems (itching, rashes, acne, warts, fungus, blisters)	☐ Yes	☐ No	Comment	
Do you wear glasses, contacts, or protective eyewear	☐ Yes	☐ No	Comment	
Have you ever had any problems with your eyes or vision	☐ Yes	☐ No	Comment	
Have you ever had any problems with your ears or hearing	☐ Yes	☐ No	Comment	
Have you ever had any problems with your stomach or intestines that lasted more than 2 weeks	☐ Yes	☐ No	Comment	
Do you use tobacco in any form	☐ Yes	☐ No	Comment	

Do you consume alcoholic beverages	☐ Yes	☐ No	Comment	
Do you want to weigh more or less than you do now	☐ Yes	☐ No	Comment	
Do you use any methods to control you weight	☐ Yes	☐ No	Comment	
Do you worry about your weight or body composition	☐ Yes	☐ No	Comment	
Do you limit or carefully control the foods you eat	☐ Yes	☐ No	Comment	
Do you try to lose weight to meet weight or image/ appearance requirements in your sport	☐ Yes	☐ No	Comment	
Does you weight affect the way you feel about yourself	☐ Yes	☐ No	Comment	
Do you worry you have lost control over how much you eat	☐ Yes	☐ No	Comment	
Do you make yourself vomit, use diuretics or laxatives after you eat	☐ Yes	☐ No	Comment	
Do you currently or have ever suffered from an eating disorder	☐ Yes	☐ No	Comment	
Do you ever eat in secret	☐ Yes	☐ No	Comment	
Are you trying or has anyone recommended that you gain or lose weight	☐ Yes	☐ No	Comment	
Are you on a special diet or do you avoid certain types of food or food groups	☐ Yes	☐ No	Comment	
Have you ever been told you have low bone density (osteopenia or osteoporosis)	☐ Yes	☐ No	Comment	

Gynecological (Female Student-Athletes)

Age of first menstrual period		
Do you have monthly periods	☐ Yes	☐ No

When was you last period

How many periods have you had in the past 12 months

Any significant menstrual irregularity ☐ Yes ☐ No Comment

Unusual menstrual cramps or pain ☐ Yes ☐ No Comment

Musculoskeletal

Please check all that apply

Please check the box if NONE of the following pertain to you ☐ NONE

Toe ☐ Sprain ☐ Strain ☐ Fracture ☐ Stress Fx ☐ Dislocation Specifics

Foot ☐ Sprain ☐ Strain ☐ Fracture ☐ Stress Fx ☐ Dislocation Specifics

Ankle ☐ Sprain ☐ Strain ☐ Fracture ☐ Stress Fx ☐ Dislocation Specifics

Shin/Calf ☐ Sprain ☐ Strain ☐ Fracture ☐ Stress Fx ☐ Dislocation Specifics

Knee
- [ ] Sprain
- [ ] Strain
- [ ] Fracture
- [ ] Stress Fx
- [ ] Dislocation

Specifics

Thigh
- [ ] Sprain
- [ ] Strain
- [ ] Fracture
- [ ] Stress Fx
- [ ] Dislocation

Specifics

Hamstring
- [ ] Sprain
- [ ] Strain
- [ ] Fracture
- [ ] Stress Fx
- [ ] Dislocation

Specifics

Hip
- [ ] Sprain
- [ ] Strain
- [ ] Fracture
- [ ] Stress Fx
- [ ] Dislocation

Specifics

Spine
- [ ] Sprain
- [ ] Strain
- [ ] Fracture
- [ ] Stress Fx
- [ ] Dislocation

Specifics

Back
- [ ] Sprain
- [ ] Strain
- [ ] Fracture
- [ ] Stress Fx
- [ ] Dislocation

Specifics

Finger
- [ ] Sprain
- [ ] Strain
- [ ] Fracture
- [ ] Stress Fx
- [ ] Dislocation

Specifics

Hand
- [ ] Sprain
- [ ] Strain
- [ ] Fracture
- [ ] Stress Fx
- [ ] Dislocation

Specifics

Wrist
- [ ] Sprain
- [ ] Strain
- [ ] Fracture
- [ ] Stress Fx
- [ ] Dislocation

Specifics

Forearm
- [ ] Sprain
- [ ] Strain
- [ ] Fracture
- [ ] Stress Fx
- [ ] Dislocation

Specifics

Elbow
- [ ] Sprain
- [ ] Strain
- [ ] Fracture
- [ ] Stress Fx
- [ ] Dislocation

Specifics

Upper Arm
- [ ] Sprain
- [ ] Strain
- [ ] Fracture
- [ ] Stress Fx
- [ ] Dislocation

Specifics

Shoulder	☐ Sprain ☐ Strain ☐ Fracture ☐ Stress Fx ☐ Dislocation	Specifics	
Chest	☐ Sprain ☐ Strain ☐ Fracture ☐ Stress Fx ☐ Dislocation	Specifics	
Neck	☐ Sprain ☐ Strain ☐ Fracture ☐ Stress Fx ☐ Dislocation	Specifics	

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

Al of the above information is complete and correct to the best of my knowledge. I authorize the University of Iowa Team Physician 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 participating as an athlete at the University of Iowa. I further agree that any medical conditions not reveal at the time of the physical examination will release the University of Iowa from any medical or financial liability.

Student-Athlete Signature

Date