WHITWORTH UNIVERSITY
MEDICAL HISTORY UPDATE FORM

DATE: _____ / _____ / _____
Month Day Year

Athlete's Name: ______________________________ Sports(s): ______________
(Last) (First) (Middle) (Nickname)

Student ID No: ______________

Date of Birth: _____ / _____ / _____ (Month Day Year) _____ / M / F (Age Sex)

Grade: Fr. So. Jr. Sr. 5th Year Sr.

Local Address or Dorm: ______________________________

Local Phone: ______________ Cell Phone: ______________

Person to notify in case of an Emergency:		Relationship:	
Address:			
	(City)	(State)	(Zip)
Home Phone: ( )		Business Phone: ( )	
Cell Phone ( )		e-Mail:	

Father's Name: ______________
Address: ______________
(City) (State) (Zip)
e-Mail: ______________
Home Phone: (______) ______________
Business Phone: (______) ______________
Cell Phone (______) ______________

Mother's Name: ______________
Address: ______________
(City) (State) (Zip)
e-Mail: ______________
Home Phone: (______) ______________
Business Phone: (______) ______________
Cell Phone (____) ______________

Marital Information (if applicable) Spouse's Name: ______________

Address: ______________ e-Mail: ______________
(City) (State) (Zip)

Home Phone: (______) ______________ Business Phone: (______) ______________ Cell Phone: (______) ______________

Name: ____

***NOTE**: **This information will be kept CONFIDENTIAL!!!**

A. MEDICAL ILLNESS: IN THE PAST YEAR HAVE YOU HAD ANY OF THE FOLLOWING:?

Chest pain while exercising	YES	NO
Fainted or nearly fainted while exercising	YES	NO
Unexplained shortness of breath or fatigue with exercise	YES	NO
Suffered from heat illness	YES	NO
Been knocked out or experienced a concussion		
Diagnosis of mononucleosis, pneumonia, other infectious virus	YES	NO
Other illnesses, please list:		

B. GENERAL MEDICAL INFORMATION:

1. Are you a Diabetic or ever been treated for Diabetes? If yes, please list the age at which your diabetes began as well as any and all medications you take for this condition:							YES	NO
2. Do you or have you ever had Anemia?	YES	NO	Sickle- cell anemia or trait?	YES	NO	Hypoglycemia (Low Blood Sugar)?	YES	NO
3. Do you have a vision defect in either one or both eyes and if yes, please specify below:							YES	NO
4. Do you wear glasses?	YES	NO	If yes, do you wear them during athletic activity?				YES	NO
5. Do you wear contact lenses?	YES	NO	If yes, do you wear them during athletic activity?				YES	NO
6. Do you have a hearing defect? If yes, please specify below and list any hearing aids worn:							YES	NO
7. Do you wear any dental appliances?	YES	NO	If so, do you wear them during athletic activity?				YES	NO
8. Have you ever suffered from or been diagnosed with Exercise Induced Asthma (EAI)? If yes, what medication(s) are you taking to control EIA?							YES	NO
9. Do you currently take any medicines or drugs? If yes, what medications or drugs are you taking, and for what reason? *This information will be kept confidential and may need follow-up if any drugs require medical exception for NCAA banned substance testing.*							YES	NO
10. Have you had either a gain or loss of ten pounds or more in the past 12 months? Specify:							YES	NO

C. GENERAL MEDICAL ALLERGIES: Please answer as to whether you are allergic to the following items?

Aspirin	YES	NO	Penicillin	YES	NO	Tetanus antitoxin or serums	YES	NO	Bee stings	YES	NO
Codeine	YES	NO	Erythromycin	YES	NO	Novocaine or other anesthetics	YES	NO	Fire ant bites	YES	NO
Sulfa Drugs	YES	NO	Ibuprofen	YES	NO	Hay Fever – dust/mold/pollen/grass	YES	NO	Wasps stings	YES	NO
Iodine	YES	NO	Acetaminophen	YES	NO	Oral Anti-inflamitories	YES	NO	Latex	YES	NO
1. Are you allergic to any other drug, medications, foods, plants, insects, etc. not listed above? If yes, please list those allergies here:										YES	NO

D. GYNECOLOGICAL HISTORY: ***ONLY FEMALES ANSWER THIS SECTION***

IN THE PAST 12 MONTHS HAVE YOU HAD ANY OF THE FOLLOWING?

	Yes	No	Years		Yes	No	Years		Yes	No	Years
Absence of Menstruation				Menstrual Cramps				Scanty Flow			
Painful Menstruation				Irregular Periods				Excessive Flow			

Are currently taking Birth Control Pills?	YES	NO	If yes, what type are you taking?

Name: ____

E. EATING DISORDERS: IN THE PAST 12 MONTHS HAVE YOU HAD ANY OF THE FOLLOWING?

1. A problem with food bingeing? If yes, when?	**YES**	**NO**
2. Been suggested or have you ever been diagnosed as being anorexic? If yes, when?	**YES**	**NO**
3. Diagnosis of bulimia? If yes, when?	**YES**	**NO**
4. Do you sometimes or often induce vomiting after eating?	**YES**	**NO**
5. Taken laxatives to prevent being overweight?	**YES**	**NO**

F. INURIES: IN THE PAST YEAR HAVE YOU HAD ANY OF THE FOLLOWING:

1. Fracture, sprain, strain that has limited your athletic participation?	**YES**	**NO**
2. Chronic injury (tendonitis) that has limited your athletic participation?	**YES**	**NO**
3. Visited a health care provider due to a condition that limited your athletic participation?	**YES**	**NO**
4. Participated in physical therapy?	**YES**	**NO**
5. Been treated by a chiropractor, massage therapist, or acupuncturist?	**YES**	**NO**
Please explain any yes answers:		

R. OTHER:

If you have any additional conditions, problems, or comments that have not been addressed in the above questionnaire, please use the space below to inform us so that we may be able to better serve you with our best medical care.

____

____

____

____

All statements and answers in the above medical history questionnaire are true and complete to the best of my knowledge. I have no abnormality, limitation, or restriction not mentioned in this record. I understand that this information is to help determine my fitness to participate in athletics, and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur.

PRINTED NAME OF ATHLETE ____
(First) **(Middle)** **(Last)**

DATE ____________________ **SIGNATURE OF ATHLETE** ______________________________

The remainder of this form is for the sports medicine staff to complete.

Name: ____

HEIGHT:________________ WEIGHT: _______________ RADIAL PULSE:_____________ BP: _____________________

BODY FAT: ________% ***F*** Tri: ____ Hip: _____ Quad: _____ ***M*** Chest _____ Ab_____ Quad _____ S/R" _____________

ORTHOPEDIC EXAM - **only if necessary due to injury history update**

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MEDICAL EXAM - **only if necessary due to medical history update**

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
HEART AUSCULTATION			ABDOMEN		
CHEST			HERNIA		
LUNGS					

Physicians Comments: ____

____

OVERALL PHYSICAL EXAMINATION RESULTS:

RESULTS	CHECK ONE	COMMENTS
PASSED WITHOUT LIMITATIONS		
PASSED PENDING THE FOLLOWING:		
FAILED DUE TO THE FOLLOWING:		

Examiner's Signature:____ Date: ___________________________

2009-2010