UNIVERSITY OF NEBRASKA

MEDICAL HISTORY FOR STUDENT ATHLETES

SPORT:_____ **DATE:**___/___/___

NAME: Last_____First_____Middle_____
Date of Birth ___/___/___ Age_____Sex_____Email Address_____
Cell Phone # _____
Lincoln Address_____Phone # ( )____- _____
Home Address_____Phone # ( )____-_____
City_____State_____Zip Code_____
Mother/Guardian_____Home Phone # ( )____- _____
Address_____Work Phone # ( )____- _____
Cell Phone # ( )____- _____
City_____State_____Zip Code_____
Father/Guardian_____Home Phone # ( )____- _____
Address_____Work Phone # ( )____- _____
Cell Phone # ( )____- _____
City_____State_____Zip Code_____
Family Physician_____City, State_____
Person to notify in case of emergency
Name_____Home Phone # ( )_____- _____
Relationship_____Work Phone # ( )_____- _____

Past Medical History:

ALLERGIES: List any allergies to MEDICATIONS, food or other (i.e. bee stings).

_____ _____

_____ _____

MEDICATIONS: List all medications you are taking and the reason for taking them.

_____ _____

SURGERIES: List any operations you have had, the date performed, and the doctor's name.

_____ _____

_____ _____

Do you have a metal implant (screw, pin, plate, staple) in your body from a previous surgery? YES NO
If yes, where?_____

MEDICAL PROBLEMS: List any major medical problem you have had and your age or the date they first occured.

_____ _____

_____ _____

INJURIES: List any major injuries and the date occurred.

_____ _____

_____ _____

HOSPITALIZATIONS: List the date and the reason for any hospitalizations.

_____ _____

_____ _____

CHILDHOOD DISEASES: Have you ever had any of these childhood diseases? Include dates.
Chicken Pox_____ Mumps_____ Measles_____ Rubella_____

IMMUNIZATIONS:
List dates of immunizations for the following diseases.
Measles, Mumps and Rubella (MMR)_____ Measles and Rubella (MR)_____ Influenza_____
Date of last tetanus immunizations._____ Meningitis_____

Please circle yes or no, or fill in the appropriate blanks.

PERSONAL HABITS:
How often do you drink alcohol?_____
Do you use tobacco? YES NO Cigarettes_____packs per day. Snuff or chewing tobacco_____

FAMILY HISTORY
Is your father alive? YES NO AGE (if living)_____Cause of death?_____Age_____
Is your mother alive? YES NO AGE (if living)_____Cause of death?_____Age_____

Do you have living brothers or sisters? YES NO Brothers (no.)_____ Sisters (no.)_____
Causes(s) of death?_____At what age(s)?_____

Has any one in your immediate family ever had any of the following medical problems and if so state the relationship to you.

TB	No	Yes_____	Gout	No	Yes_____
Diabetes	No	Yes_____	High blood pressure	No	Yes_____
Cancer	No	Yes_____	Strokes	No	Yes_____
Heart trouble	No	Yes_____	Bleeding trouble	No	Yes_____
Mental illness	No	Yes_____	Hay fever	No	Yes_____
Kidney trouble	No	Yes_____	Back trouble	No	Yes_____
Migraines	No	Yes_____			
Epilepsy	No	Yes_____			

REVIEW OF SYSTEMS:
Do you or have you had the following problems?

General

Yes	No	Have you had any blood problems?
Yes	No	Anemia
Yes	No	Abnormal bruising
Yes	No	Abnormal bleeding tendency
Yes	No	Blood clots
Yes	No	Sickle cell trait
Yes	No	Extreme tiredness or fatigue
Yes	No	Mononucleosis
Yes	No	Recent weight gain or loss
Yes	No	Diabetes
Yes	No	Thyroid problems
Yes	No	Dizzy spells
Yes	No	Have you ever blacked out or fainted?
Yes	No	Frequent enlarged lymph glands
Yes	No	Appendicitis
Yes	No	Herpes (Oral)
Yes	No	Herpes (Genital)
Yes	No	Sexually transmitted diseases
Yes	No	Car or air sickness
Yes	No	Drug dependency

Skin

Yes No Acne
Yes No Frequent rash
Yes No Eczema
Yes No Psoriasis
Yes No Dry skin
Yes No Itching
Yes No Ring worm
Yes No Skin infection including impetigo, staff infection or folliculitis

Head

Yes No Have you ever sustained a concussion?
Number of concussions_____
Yes No Have you ever sustained a head injury in which you were knocked unconscious?
Yes No Skull fracture, facial bone fracture, or nose fracture
Yes No Do you require a vision aid to participate in sports?
If yes, circle the type you require.
Glasses Contacts
Yes No Loss of vision
Yes No Frequent sinus infections
Yes No Hard of hearing
Yes No Ringing of the ears
Yes No Frequent nose bleeds
Yes No Are your tonsils removed?
Yes No Do you wear any artificial dental plates?

Heart/Lungs

Yes No Rheumatic Fever
Yes No Heart murmur
Yes No Chest pains or pressure with exertion
Yes No Shortness of breath
Yes No High blood pressure
Yes No Asthma
Yes No Chronic cough
Yes No Pneumonia
Yes No Tuberculosis

Gastrointestinal

Yes No Heartburn
Yes No Hiatal hernia
Yes No Ulcers
Yes No Chronic nausea
Yes No Vomiting blood or coffee ground-like vomitus
Yes No Blood in stools
Yes No Black tar-like stools
Yes No Chronic diarrhea
Yes No Chronic constipation
Yes No Recent change in bowel habits
Yes No Chronic abdominal pain
Yes No Hepatitis or liver problems

Urinary

Yes No Kidney or bladder infection
Yes No Burning or pain on urination
Yes No Blood in urine

Genitalia/MEN

Yes No Swellling of scrotum
Yes No Lump in testicles or scrotum
Yes No Hernia
Yes No Pain in testicle

Genitalia/WOMEN

Yes No Ovarian cyst
Yes No Chronic pelvic pain
Yes No Irregular periods
Yes No Severe cramping with periods
_____days Mentrual cycle (start to end)
_____days Duration of periods
Flow is: Light Medium Heavy
_____ Age at onset of periods
When was your last pap smear? Date:_____
When was your last menstrual period? Date:_____

Neurologic

Yes No Frequent headache
Yes No Frequent dizziness
Yes No Fainting
Yes No Epilepsy or seizures
Yes No Neck problems including stingers or burners

Performance Modifiers

Yes No Depression
Yes No Anxiety
Yes No Difficulty sleeping
Yes No Irritability
Yes No Suicidal thoughts
Yes No Hearing voices
Yes No Difficulty concentrating
Yes No Have you ever had difficulty with reading or writing skills?
Yes No Have you ever had difficulty with reversing letters in words when writing sentences?
Yes No Difficulty with memory
Yes No Would you like to talk with a counselor when you arrive on campus?
Yes No Have you ever been treated for a psychological problem?

Musculoskeletal

Upper extremity

Yes No Have you had either shoulder “pop out,” fracture or dislocate?
Yes No Have you ever fractured a collarbone, or dislocated or fractured an elbow, forearm, wrist, hand or finger?
If yes, which bone and/or joint was involved?
_____
Yes No Have you ever missed a game because of an upper extremity problem?

Spine

Yes No Has a neck strain ever caused weakness or burning of the arm or hand?
Yes No Have you ever sustained a neck fracture?
Yes No Do you have any back pain or stiffness?
Yes No Have you ever missed a game due to back trouble?
Yes No Have you ever “pinched a nerve”?

Lower extremity

Yes No Do you have hip or groin pain with playing sports?
Yes No Do you think you are prone to hamstring, thigh or groin strains?
Yes No Have you ever sustained a knee injury or

had an knee problems?

Yes No Have you ever seen a physician about a knee injury?

Yes No Have you had a knee injury that required a cast, surgery or special brace?

Yes No Have you had an ankle injury that required a case or surgery?

Yes No Have you ever sustained a fracture of the ankle or foot?

Yes No Have you ever missed a game because of a lower extremity problem?

Please note any of these medical tests that you may have had along with the injury and date:

TEST	Injury	Date	Location
Magnetic Resonance Image (MRI)	_____	_____	_____
Arthrogram	_____	_____	_____
Bone Scan	_____	_____	_____
CT Scan	_____	_____	_____
Tomogram	_____	_____	_____
12 lead EKG	_____	_____	_____
Stress EKG	_____	_____	_____

Please note any medical condition or problem other than those listed or described on this form:

_____
_____
_____
_____
_____

The undersigned, herewith,

A. Certifies that the answers to these questions are correct and true.
B. Fully realizes the University of Nebraska cannot be held responsible for any previous medical condition(s) that he/she might have.

SIGNATURE:_____

Date:_____

PLEASE READ THE FOLLOWING
CONSENT FORMS CARFULLY

(If you are under 19 years of age, your parents must also sign)

The basic content of each is:

A. Medical Consent: Allows UNL athletic trainers and physicians to treat any injury or illness incurred by you while at the University of Nebraska-Lincoln.
B. Release of Information: Allows those listed to release information concerning your injuries to the media.
C. Shared Responsibility: Provides information to you concerning certain inherent risks involved in participating in intercollegiate athletics and that you are willing to assume responsibility for such risks.

If you should choose to refuse to sign any of these, please write “Refused to Sign,” beside the appropriate document title.

MEDICAL CONSENT - Part 1

I hereby grant permission to the University of Nebraska team physicians and/or their consulting physician to render me any treatment or medical or surgical care that they deem reasonably necessary to my health and well-being.
I also hereby authorize the athletic trainers at the University of Nebraska who are under the direction and guidance of the University of Nebraska team physicians to render me any preventive, first-aid, rehabilitative or emergency treatment that they deem reasonably necessary to my health and well-being.

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

DATE:_____

_____
SIGNATURE

Signature may be that of athlete 19 years of age; if under 19, signature of parent or guardian is required.

_____
STUDENT I.D. NO.

_____
PARENT OR GUARDIAN

I hereby grant permission on behalf of my minor son or daughter or my ward.

AUTHORIZATION FOR RELEASE OF INFORMATION - Part 2

This is to authorize the University of Nebraska athletic trainers, team physicians and athletic coaches to release medical information to the University of Nebraska Media Relations Department, and the various media outlets, any information concerning illness or injury relative to my past, present or future participation in athletics at the University of Nebraska.

DATE:_____

_____
SIGNATURE

Signature may be that of athlete 19 years of age; if under 19, signature of parent or guardian is required.

_____
STUDENT I.D. NO.

_____
PARENT OR GUARDIAN

SHARED RESPONSIBILITY FOR SPORTS SAFETY - Part 3

The responsibility for sport safety must be shared by all. Included in this group should be administrators, coaches, physicians, athletic trainers, and student-athletes as well. I, the undersigned, am aware that there is a certain risk of injury involved in my participation in Intercollegiate Athletics at the University of Nebraska. I understand that my signature does not relieve the University of it’s responsibilities to me. This document is intended to make me aware of my responsibility in preventing potential injuries, complying with the treatment plan of the UNL athletic medical staff, and that there is risk of injury. I understand that this includes the risk of spinal cord and brain injury that may result in paralysis and the possibility of other permanent injury or death.

I have read the above shared responsibility statement. I acknowledge the fact that these risks exist and I am willing to assume responsibility for such risks while participating at the University of Nebraska.

Date:_____

_____