Student-Athlete's Full Name ____________________________________________________________
Last First Middle Nickname

## Medical History

Please answer each of the following questions by circling **YES** or **NO**. Fill additional information as needed. The information provided is strictly confidential and used for health care purposes only.

**Family History:**
**Has any parent, grandparent, or sibling had:**

| | | |
|---|---|---|
| Cancer | YES | NO |
| Leukemia | YES | NO |
| Tuberculosis | YES | NO |
| Diabetes | YES | NO |
| Heart disease | YES | NO |
| High blood pressure | YES | NO |
| Asthma | YES | NO |
| Liver disease | YES | NO |
| Migraine headaches | YES | NO |
| Emphysema | YES | NO |
| Stroke | YES | NO |
| Epilepsy/Seizures | YES | NO |
| Bleeding disorder | YES | NO |
| Kidney disease | YES | NO |
| Glaucoma | YES | NO |
| Sickle cell anemia | YES | NO |
| Arthritis | YES | NO |
| Alcohol or drug abuse | YES | NO |
| Nervous or mental disease | YES | NO |
| Other serious disease | YES | NO |
| Sudden death before age 50 | YES | NO |

**Medications:**

| | | |
|---|---|---|
| Are you currently taking any drugs, medicines, birth control pills, or vitamins (prescription and non-prescription)? | YES | NO |

What? ______________________________________
____________________________________________
____________________________________________

**Allergies:**

| | | |
|---|---|---|
| Latex | YES | NO |
| Penicillin | YES | NO |
| Sulfa drugs | YES | NO |
| Other antibiotics | YES | NO |
| What? ______________________ | | |
| Aspirin | YES | NO |
| Other drug/medicine | YES | NO |
| What? ______________________ | | |
| Any food item | YES | NO |
| What? ______________________ | | |
| Bee stings/Insect bites | YES | NO |
| Other allergy | YES | NO |
| What? ______________________ | | |

**Personal History:**

| | | |
|---|---|---|
| Do you smoke? | YES | NO |
| Do you use any other forms of tobacco? | YES | NO |
| If yes, what? ______________________ | | |
| How much? ______________________ | | |
| Do you drink: | | |
| Beer? | YES | NO |
| Wine? | YES | NO |
| How much? ______________________ | | |
| Do you use drugs? | YES | NO |
| Are you on a special diet? | YES | NO |
| Have you lost weight in the past year? | YES | NO |
| Are you satisfied with your weight? | YES | NO |
| Do you think you have an eating disorder? | YES | NO |

**Health History:**
**Do you now, or have you in the past had any of the following:**

| | | |
|---|---|---|
| Concussion | YES | NO |
| Loss of consciousness | YES | NO |
| Memory loss | YES | NO |
| Numbness/weakness in arm or leg | YES | NO |
| Migraine headaches | YES | NO |
| Mouth/tooth/tongue problem | YES | NO |
| Recurrent nosebleeds | YES | NO |
| Epilepsy/Seizures | YES | NO |
| Heat related illness | YES | NO |
| Glaucoma | YES | NO |
| Cataracts | YES | NO |
| Blindness (either eye) | YES | NO |
| Blurred vision (not corrected by glasses) | YES | NO |
| Ear infections | YES | NO |
| Deafness/Hearing Deficiency | YES | NO |
| Difficulty sleeping | YES | NO |
| Asthma | YES | NO |
| Shortness of breath/wheezing | YES | NO |
| Coughing up blood | YES | NO |
| Hay fever | YES | NO |
| Chronic Bronchitis | YES | NO |
| Tuberculosis | YES | NO |
| Heart murmur | YES | NO |
| Pain/pressure in chest | YES | NO |
| Rheumatic fever | YES | NO |
| High blood pressure | YES | NO |
| Mononeucleosis | YES | NO |
| Hepatitis | YES | NO |
| Acid Reflux disease | YES | NO |
| Stomach or Duodenal Cancer | YES | NO |
| Colon trouble | YES | NO |
| Rectal trouble | YES | NO |
| Bladder/Urinary tract infection | YES | NO |
| Kidney infection | YES | NO |
| Kidney stones | YES | NO |
| Loss of kidney | YES | NO |
| Other kidney disease ______________________ | | |
| Anemia | YES | NO |
| Poor blood clotting | YES | NO |
| Diabetes | YES | NO |
| Taking insulin? | YES | NO |
| Overactive thyroid | YES | NO |
| Underactive thyroid | YES | NO |
| Arthritis | YES | NO |
| Phlebitis | YES | NO |
| Recurrent boils | YES | NO |
| Changing mole | YES | NO |
| Other skin disease | YES | NO |
| What? ______________________ | | |
| Depression/Anxiety | YES | NO |
| Serious emotional illness | YES | NO |

**Health History (continued):**

| | | |
|---|---|---|
| Neck injury | YES | NO |
| Shoulder injury | YES | NO |
| What? | | |

What? ___________________________________
Wrist/hand injury YES NO
What? ___________________________________
Back injury YES NO
What? ___________________________________
Hip/thigh/groin injury YES NO
What? ___________________________________
Knee injury YES NO
What? ___________________________________
Ankle/foot/lower leg injury YES NO
What? ___________________________________
Broken bone YES NO
What? ___________________________________
Stress fracture YES NO
What? ___________________________________
Facial injury YES NO
What? ___________________________________
Surgery YES NO
Please explain. ____________________________
________________________________________

*Women*
Menstrual difficulty YES NO
Ovarian cyst YES NO
Regular periods YES NO
Breast lump YES NO
Other GYN problems _______________________
*Men*
Loss of testicle YES NO
Other ____________________________________

Please provide further information if needed for any of the previous questions.__________________
________________________________________
________________________________________
________________________________________

Do you have any condition or disease not listed on this form? YES NO
Please explain: ____________________________
________________________________________
________________________________________
________________________________________

## Authorization and Consent

**Statement by Student-Athlete or Parent/Guardian, if Student-Athlete is Under Age 18**

**This authorization allows our licensed athletic training staff to treat you, refer you to a physician for treatment, or obtain emergency treatment for you, while you are a student-athlete at St. Andrews. If you are over age 18, we will proceed without notifying parents prior to treatment. If you are under 18, your parent or legal guardian must also sign this authorization. This authorization is also required to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA was created to protect the privacy of personal health information (PHI). HIPAA regulations prohibit the disclosure of PHI unless written authorization is given. Therefore, in order to communicate with your coaches, parents/guardian, or other health care providers about your injury and/or condition, the athletic training staff must obtain your permission.**

A. I have personally reviewed the information provided in this Sports Health Information Summary and attest that it is true and complete to the best of my knowledge.
B. I understand that participation in sports requires an acceptance of risk for injury.
C. I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the athletic training staff, including physician referral. I understand that I am responsible for all medical costs incurred when physician referral is necessary.
D. I understand that I (my son/daughter) must refrain from practice or play while ill or injured until I (he/she) am/is discharged from treatment or given permission by the athletic training staff to restart participation despite continuing medical treatment.
E. I understand that having passed the sports physical examination does not necessarily mean that I (my son/daughter) am/is physically qualified to engage in intercollegiate athletics, but only that the examiner did not find a medical reason to disqualify at the time of said examination.
F. I hereby give my permission to the athletic training staff to disclose my (my son's/daughters) personal health information when it pertains to my (his/her) athletic injury/illness, treatment, and/or ability to participate in collegiate athletics to my (his/her) coaches, parents/guardian, and/or other health care providers involved in my (his/her) medical care (ie. SAPC Health and Wellness, referring physicians, etc…).
G. I understand that if I feel that my privacy has been violated without my consent, I may file a complaint to the U.S. Health and Human Resources Department.

Student-Athlete Name (print)
_____________________________________________

Signature of Student-Athlete
_____________________________________________
Date ______________________

Signature of Parent/Guardian
(if student is under age 18)
_____________________________________________
Date ______________________

## Athletic Physical Exam
## (To be completed by a physician)

**Student-Athlete's Full Name:**________________________________________ **Date:**______________

**Sport(s):**________________________________________________________________

**Age:**________ **Date of Birth:**_______________ **Social Security Number:** ______________________________

**Height:**___________ **Weight:**___________ **Blood Pressure:** _________________ **Pulse:**____________________

**Vision:** *Uncorrected:* Right 20/_____ Left 20/_____ *Corrected:* Right 20/_____ Left 20/_____
*Both:* 20/_____ Glasses/Contacts ________________________________________

**Heart:** Heart Inspection__________________________________Palpation____________________
Rhythm_________________________________ Sounds & Murmurs____________________

**Genitalia:** ________________________________________ Not Examined________________

| | Satisfactory Y | Satisfactory N | Physician's Comments | Follow-up Y | Follow-up N |
|---|---|---|---|---|---|
| Skin | [ ] | [ ] | ______________________ | [ ] | [ ] |
| Head | [ ] | [ ] | ______________________ | [ ] | [ ] |
| Ear, Nose, Throat | [ ] | [ ] | ______________________ | [ ] | [ ] |
| Eyes | [ ] | [ ] | ______________________ | [ ] | [ ] |
| Neck | [ ] | [ ] | ______________________ | [ ] | [ ] |
| Thorax and Lungs | [ ] | [ ] | ______________________ | [ ] | [ ] |
| Abdomen | [ ] | [ ] | ______________________ | [ ] | [ ] |
| Urine | [ ] | [ ] | ______________________ | [ ] | [ ] |
| Allergies | [ ] | [ ] | ______________________ | [ ] | [ ] |

**Musculoskeletal:**
General Posture/ Deformities/ Scars:______________________________________________
Neck/ Cervical-Spine/ Back:_____________________________________________________

| **Lower Extremities:** | | | | | |
|---|---|---|---|---|---|
| Hip | [ ] | [ ] | ______________________ | [ ] | [ ] |
| Thigh | [ ] | [ ] | ______________________ | [ ] | [ ] |
| Knee | [ ] | [ ] | ______________________ | [ ] | [ ] |
| Shin | [ ] | [ ] | ______________________ | [ ] | [ ] |
| Calf | [ ] | [ ] | ______________________ | [ ] | [ ] |
| Ankle | [ ] | [ ] | ______________________ | [ ] | [ ] |
| Foot | [ ] | [ ] | ______________________ | [ ] | [ ] |
| Toes | [ ] | [ ] | ______________________ | [ ] | [ ] |

| **Upper Extremities:** | | | | | |
|---|---|---|---|---|---|
| Shoulder | [ ] | [ ] | ______________________ | [ ] | [ ] |
| Arm | [ ] | [ ] | ______________________ | [ ] | [ ] |
| Elbow | [ ] | [ ] | ______________________ | [ ] | [ ] |
| Wrist, Hand, Fingers | [ ] | [ ] | ______________________ | [ ] | [ ] |

Athletic Participation Approved: Yes________ No________
Additional Comments/ Limitations:___________________________________________
________________________________________________________________
________________________________________________________________

Physician's Signature:_______________________________________ Date:________________
Physician's Office Phone Number:________________________________