Preparticipation Medical History for Athletes

Millersville University Health Services
Millersville, PA 17551-0302

Name: _______________________________Date:__________________ MU#: ____________________
Date of Birth: ______________Sport: ______________
Address: ____
In case of Emergency contact:
Name: ______________________ Relationship: _______________
Phone: (H) ____________________ (W) _____________________ (C) ________________________
Explain "Yes" answers below. Circle questions you don't know the answer to.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?			24. Do you have asthma?		
2. Have you ever been hospitalized overnight?			25. Have you ever become ill from exercising in the heat?		
3. Are you currently taking any prescription, nonprescription or herbal pills or medications?			26. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport? (ie: knee brace, foot orthotics, hearing aid)		
4. Have you ever had surgery?			27. Have you had any problems with your eyes or vision?		
5. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?			28. Do you wear glasses, contacts or protective eyewear?		
6. Do you have any allergies to pollen, medicine, food or stinging insects?			29. Have you ever had a sprain, strain or swelling after an injury?		
7. Have you ever passed out during or after exercise?			30. Have you broken any bones or dislocated a joint, or have you had any other problems with pain or swelling in muscles, tendon, bones or joints? Please explain below		
8. Have you ever had racing of your heart or skipped beats?			31. Do you want to weigh more or less than you do now?		
9. Have you ever had chest pain during or after exercise?			32. Do you lose weight regularly to meet weight requirements for your sport?		
10. Have you had high blood pressure or high cholesterol?			33. Do you feel stressed out?		
11. Have you ever been told you have a heart murmur?			34. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?		
12. Have you had high blood pressure or high cholesterol?			35. Have you or has anyone in your family had sickle cell disease/trait or thallassemia or other blood related disorder?		
13. Has any family member or relative died of heart problems or of sudden death before age 50?			**Females Only**		
14. Have you had a severe viral infection (ie: myocarditis or mononucleosis) within the last month?			1. When was your first menstrual period		
15. Has a physician ever denied or restricted your participation in sports for any heart problems?			2. When was the first day of you last menstrual period?		
16. Do you have any current skin problems (ie: itching, rashes, warts or blisters)?			3. How much time do you usually have from the start of one period to the start of the next?		
17. Have you ever been knocked out, become unconscious, or lost your memory?			4. What was the longest time between periods in the last year?		
18. Have you ever had a head injury or concussion?			Explain "Yes" answers here:		
19. Have you ever had a seizure?					
20. Do you have frequent headaches?					
21. Have you ever had numbness or tingling in your arms, hands, legs, or feet?					
22. Have you ever had a stinger, burner or pinched nerve?					
23. Do you cough, wheeze or have trouble breathing?					

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete: ___________________________________ Date: ____________________
Reviewed on (RN initial and date): _______ _______ _______ _______ _______