Preparticipation Medical History for Athletes

Millersville University Health Services
Millersville, PA 17551-0302

Name: ____________________ Date: __________ MU#: ______________
Date of Birth: __________ Phone______________________ 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.

#	Question	Y	N
1.	Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
2.	Have you ever been hospitalized overnight in the past year?	☐	☐
	Have you ever had surgery?	☐	☐
3.	Have you ever passed out during or after exercise?	☐	☐
	Have you ever had chest pain during or after exercise?	☐	☐
	Have you ever had racing of your heart or skipped beats?	☐	☐
	Have you had high blood pressure or high cholesterol?	☐	☐
	Have you ever been told you have a heart murmur?	☐	☐
	Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
	Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm?	☐	☐
	Have you had a severe viral infection (i.e.: myocarditis or mononucleosis) within the last month?	☐	☐
	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
4.	Have you ever had a head injury or concussion?	☐	☐
	Have you ever been knocked out, become unconscious, or lost your memory? If yes, how many times? ______	☐	☐
	When was the last concussion? ___________		
	How severe was each one? (Explain below)		
	Have you ever had a seizure?	☐	☐
	Do you have frequent or severe headaches?	☐	☐
	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
	Have you ever had a stinger, burner or pinched nerve?	☐	☐
5.	Are you missing any paired organs?	☐	☐
6.	Are you under a doctor's care	☐	☐
7.	Are you currently taking any prescription or non-prescription (over the counter) medication or pills or using an inhaler?	☐	☐
8.	Do you have any allergies to pollen, medicine, food or stinging insects?	☐	☐
9.	Do you have any current skin problems (i.e.: itching, rashes, warts, fungus, or blisters)?	☐	☐
10.	Have you ever become ill from exercising in the heat?	☐	☐
11.	Have you had any problems with your eyes or vision?	☐	☐
13.	Have you ever gotten short of breath with exercise?	☐	☐
	Do you have asthma?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐
14.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position? (i.e.: knee brace, neck roll, foot orthotics, hearing aid)	☐	☐
15.	Have you ever had a sprain, strain or swelling after an injury?	☐	☐
	Have you broken any bones or dislocated a joint, or had any other problems with pain or swelling in muscles, tendon, bones or joints?	☐	☐

If yes, check the appropriate boxes below

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper Arm		☐ Foot

#	Question	Y	N
16.	Do you want to weight more or less than you do now?	☐	☐
17.	Do you feel stressed out?	☐	☐
18.	Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	☐	☐
19.	Have you or has anyone in your family had sickle cell disease/trait or thallassemia or other blood related disorders	☐	☐

FEMALES ONLY

20. When was your first menstrual period? ____________
When was your most recent menstrual period? ____________
Have much time usually elapses from the start of one period to the next? ____________
How many periods have you had in the last year? ____________
What was the longest time between periods in the last year? ______

Explain 'Yes' answers in the box below

____
____
____
____

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: initial & date ____________ ____________ ____________ ____________