



**WESLEYAN UNIVERSITY**  
**MEDICAL HISTORY FORM**  
**2007-08**

Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Wes ID # \_\_\_\_\_ SS# \_\_\_\_\_  
 Class Yr. \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex M F

Sport (F) _____
Sport (W) _____
Sport (S) _____

**ADDRESS:**

Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Email Address \_\_\_\_\_

**EMERGENCY CONTACT:**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 Street \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Relation \_\_\_\_\_

**MEDICAL:**

Are you currently under the care of a physician? Yes No  
 If so, what for? \_\_\_\_\_

Are you taking any medications? Yes No  
 If so, what? \_\_\_\_\_

Do you presently have or in the past had problems with any of the following?  
 Circle all that apply, comment at the end.

- |                        |                             |
|------------------------|-----------------------------|
| Mononucleosis          | Sickle Cell Trait           |
| Rheumatic Fever        | Serious Accident/Injury     |
| Meningitis             | Hepatitis                   |
| Tuberculosis           | Crohn's/Ulcerative Colitis  |
| HIV/AIDS               | Back Problems               |
| Vision Impairment      | Joint Injury                |
| Hearing Impairment     | Chronic Pain                |
| Neuromuscular Disorder | Skin Disease                |
| Glasses/Contacts       |                             |
| Diabetes               | <u>WOMEN:</u>               |
| Asthma                 | Irregular menstrual periods |
| Ulcers                 | Gynecological disorder      |
| Arthritis              |                             |
| Anemia                 | <u>MEN:</u>                 |
| Cancer                 | Undescended testicle        |
| Serious Illness        | Testicular Cancer           |
| Dehydration Illness    | Inguinal hernia             |

Please comment on any significant medical issues.

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Have you ever had surgery and if so when and what type? \_\_\_\_\_

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**Allergies:** Medications \_\_\_\_\_  
 Food \_\_\_\_\_  
 Insects/Other \_\_\_\_\_

**Cardiac History:**

	Yes	No	Explain "Yes" answers here:
Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
			_____
Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	_____
			_____
Have you ever been told you should get an EKG, Echocardiogram, stress test or other cardio test?	<input type="checkbox"/>	<input type="checkbox"/>	_____
			_____
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
			_____

**Concussion History:** Please list date and severity of all concussions you have had:

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**Orthopedic/Sports Medicine History:**

Have you ever injured (sprain, strain, dislocation, subluxation, separation, fracture, herniation, etc.) or consulted a physician about any of the following body parts?

Body Part	Yes	No	Date(s)	Details
Head				
Neck				
Chest Wall				
Lower Back				
Shoulder				
Elbow				
Wrist				
Hand/Finger				
Pelvis/Hip				
Thigh				
Knee				
Lower Leg				
Ankle				
Foot/Toe				
Other				

\_\_\_\_\_ Have you been found to have only one normal functioning organ of the usually paired organs? (i.e. kidneys, eyes, testicles, ovaries)

\_\_\_\_\_ Have you ever had a cervical spine injury?

\_\_\_\_\_ Has anyone in your family had diabetes, cancer, bleeding tendencies, stroke, heart disease, lung disease, hypertension or other significant diseases or medical conditions?

\_\_\_\_\_ Have you ever been diagnosed with an eating disorder? Do you have concerns that you may have an undiagnosed eating disorder?

\_\_\_\_\_ Do you know or do you believe there is any health reason why your participation should be limited in any way?

\_\_\_\_\_ Do you wish to discuss any health concerns with an athletic trainer, nurse practitioner, nutritionist, psychologist or physician?

The undersigned, herewith,

- a. Understands that having passed the pre-participation screening does not necessarily mean that the athlete is physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify the athlete.
- b. Understands that the athlete must report all injuries and illnesses to Athletic Injury Care if subject to activity risks.
- c. Understands that the athlete must refrain from practice or play during medical treatment if instructed by Athletic Injury Care or physician.
- d. Certifies that the answers are correct and true.
- e. Understands that giving false information could disqualify the athlete from the team.

### **Insurance Information**

1. Is the athlete covered by Wesleyan insurance?    **Y**    **N**
2. Is the athlete covered by parent/guardian's insurance?    **Y**    **N**
3. Please include photocopies of insurance cards (both front and back).

I, \_\_\_\_\_, hereby acknowledged and understand that I must be covered by primary health insurance while a student at Wesleyan University. This coverage is typically either the Wesleyan student insurance or coverage through a parent/guardian. If this primary health insurance is to lapse I understand that it is my responsibility to notify the athletic administration and I will become ineligible until I retain other coverage. Also, I understand that the Wesleyan University sports policy has a \$500.00 deductible and thus is to be used for instances where there is a remaining balance on a claim in which the deductible has been met.

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Signature

Date

## Consent and Acknowledgement Form

Timely exchange of medical information is crucial to establishing fitness for participation as well as rendering care for a sick or injured athlete. I consent to the use or disclosure of my protected health information by Wesleyan University Athletics to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations, this includes but is not limited to coaches, athletic trainers, team physicians, and administrative athletic staff. Protected health information used or disclosed by us may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that this consent is effective for as long as Athletics maintains my protected health information. Limited health information is kept by Athletic Injury Care in protected physical and computer files. The balance of health information is kept at Davison Health Center per Notice of Privacy Practices.

I, undersigned, have been informed, understand, and appreciate that there are inherent risks involved in intercollegiate athletics. I have been informed, understand and appreciate that these risks may involve serious injuries to the head, neck, internal organs, or other structures of the body, which may result in permanent disability, paralysis, or even death.

By signing below, I acknowledge that I have read and understood this consent and acceptance of risk statement:

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Signature of Student

Date

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Signature of Parent/Guardian (if under 18)

Date

Please mail completed form to:

Athletic Injury Care  
Wesleyan University  
161 Cross Street  
Freeman Athletic Center  
Middletown, CT 06459

***For Office Use Only***  
***ATC initials verifying review of the form***

\_\_\_\_\_ Initials/Date

\_\_\_\_\_ BP/Pulse

***Recheck***

\_\_\_\_\_ Initials/Date

\_\_\_\_\_ BP/Pulse

***Recheck***

\_\_\_\_\_ Initials/Date

\_\_\_\_\_ BP/Pulse