



UNIVERSITY OF ILLINOIS SPRINGFIELD
Campus Health Services
ATHLETIC MEDICAL HISTORY

INSURANCE QUESTION

Insurance on file at UIS?	Y <input type="checkbox"/> N <input type="checkbox"/>
Name:	_____
Policy Number:	_____
Preferred Provider Program?	Y <input type="checkbox"/> N <input type="checkbox"/>
HMO	Y <input type="checkbox"/> N <input type="checkbox"/>

Date of Exam: _____

Name: _____ Personal MD: _____ Date of birth: _____

Sex: _____ Age: _____ UIN: _____ Sport(s): _____

Address: _____ Cell/phone#: _____

Medicines: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

Allergies: Do you have allergies yes/no. If yes, please identify specific allergy below and write what reaction you had. Pollens Food Stinging Insects Medicines

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital? Why?		
4. Have you ever had a surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get tight-headed or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
12. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
13. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
14. Does anyone in your family have a heart problem, pacemaker, or implant defibrillator?		
15. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
16. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
17. Have you ever had any broken or fractured bones or dislocated joints?		
18. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
19. Have you ever had a stress fracture?		
20. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
21. Do you regularly use a brace, orthotics, or other assistive device?		
22. Do you have a bone, muscle, or joint injury that bothers you?		
23. Do any of your joints become painful, swollen, feel warm, or look red?		
24. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
25. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
26. Have you ever used an inhaler or taken asthma medicine?		
27. Is there anyone in your family who has asthma?		
28. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
29. Do you have groin pain or a painful bulge or hernia in the groin area?		
30. Have you had infectious mononucleosis (mono) within the last month?		
31. Do you have any rashes, pressure sores, or other skin problems?		
32. Have you had a herpes or MRSA skin infection?		
33. Have you ever had a head injury or concussion?		
34. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, memory problems, or loss of consciousness?		
35. Do you have a history of seizure disorder?		
36. Do you have headaches with exercise?		
37. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
38. Have you ever been unable to move your arms or legs after being hit or falling?		
39. Have you ever become ill while exercising in the heat?		
40. Do you get frequent muscle cramps when exercising?		
41. Do you or someone in your family have sickle cell trait or disease?		
42. Have you had any problems with your eyes or vision?		
43. Have you had any eye injuries?		
44. Do you wear glasses or contact lenses?		
45. Do you wear protective eye-wear, such as goggles or a face shield?		
46. Do you worry about your weight?		
47. Are you trying to or has anyone recommended that you gain or lose weight?		
48. Are you on a special diet or do you avoid certain types of foods?		
49. Have you ever had an eating disorder?		
50. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
51. Have you ever had a menstrual period?		
52. How old were you when you had your first menstrual period?		
53. How many periods have you had in the last 12 months?		

Explain "Yes" answers here:

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

Signature of athlete _____ Signature of parent/guardian _____ Date _____



UNIVERSITY OF ILLINOIS SPRINGFIELD

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PHYSICAL EXAMINATION FORM

Name: UIN: Sport: Date:

Good Health Practices

1. Consider additional questions on more sensitive issues

- Do you feel stressed out or under a lot of pressure?
• Do you ever feel sad, hopeless, depressed, or anxious?
• Do you feel safe at your home or residence?
• Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
• During the past 30 days, did you use chewing tobacco, snuff, or dip?
• Do you drink alcohol or use any other drugs?
• Have you ever taken anabolic steroids or used any other performance supplement?
• Have you ever taken any supplements to help you gain or lose weight or improve your performance?
• Do you wear a seat belt/ use a helmet/ use condoms?

2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

Table with columns: EXAMINATION, U/A, WBC, Nit, Prot, ph, bld, Sp.gr, Ket, Gluc. Rows include: Height, Weight, M or F, Immunizations Current, Hct, BP, Vision R20, L20, Corrected, MEDICAL, Appearance, Eyes/ears/nose/throat, Lymph Nodes, Heart, Pulses, Lungs, Abdomen, Genitourinary, Skin, Neurological exam.

a) Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
b) Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Clear for all sports without restriction
Clear for all sports without restriction or with recommendation for further evaluation or treatment for
Not cleared: Pending further evaluation, For any sports, For certain sports

Reason

Recommendations

REPEAT U/A, WBC, Nit, Prot, ph, bld, Sp.gr, Ket, Gluc

Table with columns: MUSCULOSKELETAL, NORMAL, ABNORMAL FINDINGS. Rows include: Neck, Back, Shoulder/arm, Elbow/forearm, Wrist/hand/fingers, Hip/thigh, Knee, Leg, Ankle, Foot/toes, Functional (Duck-walk, single leg hop).

- Clear for all sports without restriction
Clear for all sports without restriction or with recommendation for further evaluation or treatment for
Not cleared: Pending further evaluation, For any sports, For certain sports

Reason

Recommendations

I have examined the above-named student and completed the preparticipation evaluation. The athlete does not present apparent clinical contraindications to practice and/or participate in the sport(s) as outlined above. A copy of the physical exam is on record in the CHS office. If conditions arise after the athlete has been cleared for participation, UIS physicians may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians with the athlete's consent).

Medical Provider (print) Signature for Medical Date
Orthopedic/ATC Provider (print) Signature for Orthopedic/ATC Date