

**Form A**  
**2011-12**

NAME \_\_\_\_\_  
Student ID # \_\_\_\_\_  
Sport \_\_\_\_\_

**The University of Texas at Tyler**  
**Pre-Participation Medical History**

Eligibility Year (Fr/So/Jr/Sr) _____	Sex _____	Age _____	DOB _____
Local Address _____		Cell or Contact _____	
		Phone _____	
<i>In case of emergency contact</i>			
Name _____	Relationship _____	Phone (H) _____	(W) _____

Explain "Yes" answers below.

- |   |   |           |       |     |      |         |       |      |       |      |       |      |           |          |        |       |           |  |      |         |         |             |            |  |  |  |  |  |  |  |  |  |  |
|---|---|-----------|-------|-----|------|---------|-------|------|-------|------|-------|------|-----------|----------|--------|-------|-----------|--|------|---------|---------|-------------|------------|--|--|--|--|--|--|--|--|--|--|
| <p>1. Have you had a medical illness or injury since your last check up or sports physical? <span style="float:right">Yes [ ] No [ ]</span></p> <p>2. Do you have an ongoing or chronic illness? <span style="float:right">[ ] [ ]</span></p> <p>3. Have you ever been hospitalized overnight? <span style="float:right">[ ] [ ]</span></p> <p>4. Have you ever had surgery? <span style="float:right">[ ] [ ]</span></p> <p>5. Are you currently taking any prescription or non-prescription (over the counter) medications or pills or using an inhaler? <span style="float:right">[ ] [ ]</span></p> <p>6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? <span style="float:right">[ ] [ ]</span></p> <p>7. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? <span style="float:right">[ ] [ ]</span></p> <p>8. Have you ever passed out during or after exercise? <span style="float:right">[ ] [ ]</span></p> <p>9. Have you ever been dizzy during or after exercise? <span style="float:right">[ ] [ ]</span></p> <p>10. Have you ever had chest pain during or after exercise? <span style="float:right">[ ] [ ]</span></p> <p>11. Do you get tired more quickly than your friends do during exercise? <span style="float:right">[ ] [ ]</span></p> <p>12. Have you ever had racing of your heart or skipped heartbeats? <span style="float:right">[ ] [ ]</span></p> <p>13. Have you ever had high blood pressure or high cholesterol? <span style="float:right">[ ] [ ]</span></p> <p>14. Have you ever been told you have a heart murmur? <span style="float:right">[ ] [ ]</span></p> <p>15. Has any family member or relative died of heart problems or of sudden death before age 50? <span style="float:right">[ ] [ ]</span></p> <p>16. Have you had a severe viral infection (for example, myocarditis or mononucleosis within the last month)? <span style="float:right">[ ] [ ]</span></p> <p>17. Has a physician ever denied or restricted your participation in sports for any heart problems? <span style="float:right">[ ] [ ]</span></p> <p>18. Do you have any current skin problems (for example, Itching, rashes, acne, warts, fungus, or blisters)? <span style="float:right">[ ] [ ]</span></p> <p>19. Have you ever had a head injury or concussion? <span style="float:right">[ ] [ ]</span></p> <p>20. Have you ever been knocked out, become unconscious, or lost your memory? <span style="float:right">[ ] [ ]</span></p> <p>21. Have you ever had a seizure? <span style="float:right">[ ] [ ]</span></p> <p>22. Do you have frequent or severe headaches? <span style="float:right">[ ] [ ]</span></p> <p>23. Have you ever had numbness or tingling in your arms, hands, legs, or feet? <span style="float:right">[ ] [ ]</span></p> <p>24. Have you ever had a stinger, burner, or pinched nerve? <span style="float:right">[ ] [ ]</span></p> <p>25. Have you ever become ill from exercising in the heat? <span style="float:right">[ ] [ ]</span></p> <p>26. Do you cough, wheeze, or have trouble breathing during or after activity? <span style="float:right">[ ] [ ]</span></p> <p>27. Do you have asthma? <span style="float:right">[ ] [ ]</span></p> <p>28. Do you have seasonal allergies that require medical treatment? <span style="float:right">[ ] [ ]</span></p> | <p>29. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position - for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid? <span style="float:right">Yes [ ] No [ ]</span></p> <p>30. Have you had any problems with your eyes or vision? <span style="float:right">[ ] [ ]</span></p> <p>31. Have you ever had a sprain, strain, or swelling after injury? <span style="float:right">[ ] [ ]</span></p> <p>32. Have you broken or fractured any bones or dislocated any joints? <span style="float:right">[ ] [ ]</span></p> <p>33. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? <span style="float:right">[ ] [ ]</span><br/><i>If yes, check appropriate box and explain below:</i></p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">Head</td> <td style="width:33%;">Elbow</td> <td style="width:33%;">Hip</td> </tr> <tr> <td>Neck</td> <td>Forearm</td> <td>Thigh</td> </tr> <tr> <td>Back</td> <td>Wrist</td> <td>Knee</td> </tr> <tr> <td>Chest</td> <td>Hand</td> <td>Shin/Calf</td> </tr> <tr> <td>Shoulder</td> <td>Finger</td> <td>Ankle</td> </tr> <tr> <td>Upper Arm</td> <td></td> <td>Foot</td> </tr> </table> <p>34. Do you want to weigh more or less than you do now? <span style="float:right">[ ] [ ]</span></p> <p>35. Do you lose weight regularly to meet weight requirements for your sport? <span style="float:right">[ ] [ ]</span></p> <p>36. Do you feel stressed out? <span style="float:right">[ ] [ ]</span></p> <p>37. Record the dates of your most recent <u>immunizations shots</u> for:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">Tetanus</td> <td style="width:50%;">Measles</td> </tr> <tr> <td>Hepatitis B</td> <td>Chickenpox</td> </tr> </table> <p><b>FEMALES ONLY</b></p> <p>38. When was your first menstrual period?</p> <p>39. When was your most recent menstrual period?</p> <p>40. How much time do you usually have from the start of one period to the start of another?</p> <p>41. How many periods have you had in the last year?</p> <p>42. What was the longest time between periods in the last year?</p> <p><b>PLEASE EXPLAIN "YES" ANSWERS BELOW:</b></p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table> | Head      | Elbow | Hip | Neck | Forearm | Thigh | Back | Wrist | Knee | Chest | Hand | Shin/Calf | Shoulder | Finger | Ankle | Upper Arm |  | Foot | Tetanus | Measles | Hepatitis B | Chickenpox |  |  |  |  |  |  |  |  |  |  |
| Head  | Elbow   | Hip       |       |     |      |         |       |      |       |      |       |      |           |          |        |       |           |  |      |         |         |             |            |  |  |  |  |  |  |  |  |  |  |
| Neck  | Forearm   | Thigh     |       |     |      |         |       |      |       |      |       |      |           |          |        |       |           |  |      |         |         |             |            |  |  |  |  |  |  |  |  |  |  |
| Back  | Wrist   | Knee      |       |     |      |         |       |      |       |      |       |      |           |          |        |       |           |  |      |         |         |             |            |  |  |  |  |  |  |  |  |  |  |
| Chest   | Hand  | Shin/Calf |       |     |      |         |       |      |       |      |       |      |           |          |        |       |           |  |      |         |         |             |            |  |  |  |  |  |  |  |  |  |  |
| Shoulder  | Finger  | Ankle     |       |     |      |         |       |      |       |      |       |      |           |          |        |       |           |  |      |         |         |             |            |  |  |  |  |  |  |  |  |  |  |
| Upper Arm   |   | Foot      |       |     |      |         |       |      |       |      |       |      |           |          |        |       |           |  |      |         |         |             |            |  |  |  |  |  |  |  |  |  |  |
| Tetanus   | Measles   |           |       |     |      |         |       |      |       |      |       |      |           |          |        |       |           |  |      |         |         |             |            |  |  |  |  |  |  |  |  |  |  |
| Hepatitis B   | Chickenpox  |           |       |     |      |         |       |      |       |      |       |      |           |          |        |       |           |  |      |         |         |             |            |  |  |  |  |  |  |  |  |  |  |
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|   |   |           |       |     |      |         |       |      |       |      |       |      |           |          |        |       |           |  |      |         |         |             |            |  |  |  |  |  |  |  |  |  |  |

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

Athlete's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Required if athlete is under 18 years of age)