I. MEDICAL HISTORY

PLEASE PRINT LEGIBLY. Please answer questions by placing an “x” in the blank or circling yes or no. Explain any “x” or “yes” answers in the space provided.

I. Do you now have or have you ever had:

- [ ] Allergy
- [ ] Heat Exhaustion/Stroke
- [ ] Asthma
- [ ] Hepatitis
- [ ] High/Low Blood Sugar
- [ ] Measles
- [ ] Diabetes
- [ ] Seizures/Epilepsy
- [ ] Hernia
- [ ] Mononucleosis
- [ ] Sickle Cell
- [ ] Pneumonia
- [ ] Heart Murmur
- [ ] Chest Pain
- [ ] Rheumatic Fever
- [ ] Tuberculosis
- [ ] Abnormal Pulse
- [ ] High Blood Pressure
- [ ] Eating Disorder
- [ ] Birth Deformities
- [ ] Mental Problems
- [ ] Unusual Shortness of Breath

II. Have you ever had an illness/injury involving the following?

- [ ] Head
- [ ] Neck/Back
- [ ] Shoulder
- [ ] Arm
- [ ] Elbow
- [ ] Wrist
- [ ] Hand
- [ ] Chest/Breast
- [ ] Hip
- [ ] Thigh
- [ ] Abdomen/Pelvis
- [ ] Knee
- [ ] Calf
- [ ] Ankle
- [ ] Foot
- [ ] Heart

III. Menstrual History (FEMALES ONLY)

[ ] Age of Onset  [ ] Interval Between Periods  [ ] Duration  
[ ] Require Medication  [ ] Birth Control Pills  [ ] Menstrual Problems

IV. Do you have a family history of….? ("Y" or "N")

- [ ] Sudden Death at a Young Age
- [ ] Heart Disease/Heart Attack
- [ ] High Blood Pressure
- [ ] Syncope (Passing Out)
- [ ] Sickle Cell Disease or Trait

V. Circle the appropriate answer to the following questions:

- **Yes**  **No**  1. Have you ever had a concussion? If YES, How many? ______
- **Yes**  **No**  2. Have you ever had a "burner" or "stinger"? If YES, How many? ______
- **Yes**  **No**  3. Have you ever passed out?
- **Yes**  **No**  4. Has your physical activity ever been limited by a heart problem?
- **Yes**  **No**  5. Have you ever been withheld from sports for a medical reason?
- **Yes**  **No**  6. Do you wear glasses or contacts while playing?
- **Yes**  **No**  7. Have you any dead, missing, chipped or broken teeth?
- **Yes**  **No**  8. Do you wear dental appliances (braces/dentures)?
- **Yes**  **No**  9. Have you had any neck, back, vertebrae, or disc injuries?
- **Yes**  **No**  10. Have you had any neck or back surgery?
- **Yes**  **No**  11. Do you experience any back pain? Frequency? _________________________
- **Yes**  **No**  12. Have you had any knee ligament or meniscus injury?
- **Yes**  **No**  13. Have you experienced any ankle sprain/surgery?
- **Yes**  **No**  14. Have you had any fractures?
  Type/location and dates:________________________________________
- **Yes**  **No**  15. Have you ever had any joint dislocations?
  Type/location and dates:________________________________________
- **Yes**  **No**  16. Have you had surgery?
  Type/location and dates:________________________________________
- **Yes**  **No**  17. Do you have a pin, screw or plate?
  Type/location and dates:________________________________________
- **Yes**  **No**  18. Are you taking any medication?
  LIST ALL:________________________________________
- **Yes**  **No**  19. Are you allergic to any medication?
  LIST ALL:________________________________________

___________________________________________________________

Signature
II. PERSONAL CONTACT INFORMATION

STUDENT-ATHLETE: ________________________________

PARENTS NAMES: ________________________________

PERMANENT ADDRESS: ________________________________

CITY: __________________ STATE: _______ ZIP: _______

SS#: _______ DATE OF BIRTH: ___________

HOME PHONE: _____________________ PARENT WORK PHONE: _____________________

PARENT EMAIL: ________________________________

SCHOOL CONTACT INFORMATION

Local Street Address: _________________________ City: ____________ Zip: ____________

Personal/Cell Phone: ___________________ Dates: ___________________

Personal Email: ________________________________

Local Street Address: _________________________ City: ____________ Zip: ____________

Personal/Cell Phone: ___________________ Dates: ___________________

Personal Email: ________________________________

Local Street Address: _________________________ City: ____________ Zip: ____________

Personal/Cell Phone: ___________________ Dates: ___________________

Personal Email: ________________________________

Local Street Address: _________________________ City: ____________ Zip: ____________

Personal/Cell Phone: ___________________ Dates: ___________________

Personal Email: ________________________________

STUDENT-ATHLETE INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:

Company Name: ________________________________

Address: _____________________________________________

City: __________________ State: _______ Zip: _______

Company Phone No. ________________________________

PLAN NUMBER: ________________ POLICY NUMBER: ________________

GROUP NUMBER: ________________ MEMBER NUMBER: ________________

Employee Name: ________________________________

Employee ID Number: ________________________________

With few exceptions, you are entitled on your request to be informed about the information UTD collects about you. Under Sections 552.021 and 552.023 of the Texas Government Code, you are entitled to receive and review the information. Under Section 559.004 of the Texas Government Code, you are entitled to have UTD correct information about you that is held by us and that is incorrect, in accordance with the procedures set forth in The University of Texas System Procedures Memorandum 32. The information that UTD collects will be retained and maintained as required by Texas records retention laws (Section 441.180 et seq. of the Texas Government Code) and rules. Different types of information are kept for different periods of time.

The "Public Information Officer" of UTD is the Vice President for Business Affairs. He is the designated agent for coordinating responses to requests for public information appropriately submitted to UTD. He can be reached at (972) 883-2213 or by fax at (972) 883-2212.
III. PHYSICAL EXAMINATION  
(THIS SECTION TO BE COMPLETED BY PHYSICIAN)

Height: _________  Weight: __________  Blood Pressure: _______/_________  Pulse:_________

<table>
<thead>
<tr>
<th>NOR / ABN</th>
<th>General</th>
<th>Musculoskeletal</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>Eyes/Vision R: 20/___  L: 20/___</td>
<td>CORRECTED: R: 20/___  L: 20/___</td>
</tr>
<tr>
<td>___</td>
<td>Ears: Hearing, Canals, Drums</td>
<td></td>
</tr>
<tr>
<td>___</td>
<td>Nose: Septum, Obstructions</td>
<td></td>
</tr>
<tr>
<td>___</td>
<td>Mouth: Membranes, Throat, Tonsils, Teeth</td>
<td></td>
</tr>
<tr>
<td>___</td>
<td>Chest, Lungs:</td>
<td></td>
</tr>
<tr>
<td>___</td>
<td>Heart:</td>
<td></td>
</tr>
<tr>
<td>___</td>
<td>Abdomen / Pelvis / Hernia:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NOR / ABN</th>
<th>Musculoskeletal</th>
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<tbody>
<tr>
<td>___</td>
<td>Spine:</td>
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<tr>
<td>___</td>
<td>Shoulders:</td>
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<td>Elbows:</td>
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<td>___</td>
<td>Wrist/Hands:</td>
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<td>___</td>
<td>Hips/Thighs:</td>
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<td>___</td>
<td>Knees:</td>
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<td>___</td>
<td>Ankles:</td>
</tr>
<tr>
<td>___</td>
<td>Feet:</td>
</tr>
</tbody>
</table>

LIMITATIONS or Special Equipment:  

HOLD for Testing:  Yes  No   

CLEARED for Participation:  _________  NOT CLEARED:  _________  

---------------------------------  
Physicians Signature
I UNDERSTAND that once this examination is completed by a physician and signed, I releaser the University of Texas at Dallas from any medical expenses resulting from athletic injuries or illnesses sustained while participating for UT Dallas.
V. MEDICAL HISTORY UPDATE
(THIS SECTION TO BE UPDATED ANNUALLY BY STUDENT-ATHLETE)

2ND YEAR UPDATE
Describe any illnesses, injuries or surgeries incurred since your last physical exam:

ILLNESS:____________________________________________________________________________________________

INJURY:____________________________________________________________________________________________

SURGERY:___________________________________________________________________________________________

ARE YOU HAVING ANY PROBLEMS AT THIS TIME? (Please specify) ____________________________________________

__________________________________________________________

DATE ____________________________ STUDENT-ATHLETE SIGNATURE __________________________

3RD YEAR UPDATE
Describe any illnesses, injuries or surgeries incurred since your last physical exam:

ILLNESS:____________________________________________________________________________________________

INJURY:____________________________________________________________________________________________

SURGERY:___________________________________________________________________________________________

ARE YOU HAVING ANY PROBLEMS AT THIS TIME? (Please specify) ____________________________________________

__________________________________________________________

DATE ____________________________ STUDENT-ATHLETE SIGNATURE __________________________

4TH YEAR UPDATE
Describe any illnesses, injuries or surgeries incurred since your last physical exam:

ILLNESS:____________________________________________________________________________________________

INJURY:____________________________________________________________________________________________

SURGERY:___________________________________________________________________________________________

ARE YOU HAVING ANY PROBLEMS AT THIS TIME? (Please specify) ____________________________________________

__________________________________________________________

DATE ____________________________ STUDENT-ATHLETE SIGNATURE __________________________

ADDITIONAL YEAR UPDATE
Describe any illnesses, injuries or surgeries incurred since your last physical exam:

ILLNESS:____________________________________________________________________________________________

INJURY:____________________________________________________________________________________________

SURGERY:___________________________________________________________________________________________

ARE YOU HAVING ANY PROBLEMS AT THIS TIME? (Please specify) ____________________________________________

__________________________________________________________

DATE ____________________________ STUDENT-ATHLETE SIGNATURE __________________________
VI. CARDIOVASCULAR SCREENING EXAMINATION

CARDIOVASCULAR HISTORY (To be filled out by student-athlete)

1. Have you ever had exertional chest pain? .......................................................... Y N Y N Y N
2. Do you have prior exertional syncope or near syncope? ................................. Y N Y N Y N
3. Do you have excessive or unexplained shortness of breath or fatigue with exercise? .......................................................... Y N Y N Y N
4. Do you have a prior history of heart murmur or increased blood pressure? ...... Y N Y N Y N
5. Does your family have a history of premature death from cardiovascular disease in a relative younger than 50 years of age? ................................. Y N Y N Y N
6. Does your family have a history of hypertrophic cardiomyopathy or dilated cardiomyopathy, long QT syndrome, or Marfan’s syndrome? ......... Y N Y N Y N

DATE: ________________________________ (INITIALS) (INITIALS) (INITIALS)

(THIS SECTION TO BE COMPLETED BY PHYSICIAN)

INITIAL EXAMINATION

BLOOD PRESSURE: _________ / _________ PULSE: ______________________

PRECORDIAL AUSCULTATION: ____________________________________________

RECOGNITION OF MARFAN’S SYNDROME: ________________________________

COMMENTS: ____________________________________________________________

______________________________________________________________________

______________________________________________________________________

DATE: ________________________________ PHYSICIAN SIGNATURE: ____________

3RD YEAR FOLLOWUP EXAMINATION

BLOOD PRESSURE: _________ / _________ PULSE: ______________________

PRECORDIAL AUSCULTATION: ____________________________________________

RECOGNITION OF MARFAN’S SYNDROME: ________________________________

COMMENTS: ____________________________________________________________

______________________________________________________________________

______________________________________________________________________

DATE: ________________________________ PHYSICIAN SIGNATURE: ____________

5TH YEAR FOLLOWUP EXAMINATION

BLOOD PRESSURE: _________ / _________ PULSE: ______________________

PRECORDIAL AUSCULTATION: ____________________________________________

RECOGNITION OF MARFAN’S SYNDROME: ________________________________

COMMENTS: ____________________________________________________________

______________________________________________________________________

______________________________________________________________________

DATE: ________________________________ PHYSICIAN SIGNATURE: ____________