

**UNIVERSITY OF NEVADA, LAS VEGAS
ATHLETIC TRAINING**

MEDICAL HISTORY INFORMATION FORM

Date _____

Name: Last _____ First _____ Middle _____

SS# ____ - ____ - ____ Date of Birth ____ / ____ / ____ Age ____ Sex ____

Sport _____ Marital Status _____

Permanent Address

Street _____ Phone ____ - ____ - ____

City _____ State _____ Zip Code _____

Father / Guardian (Name) _____

Street _____

City _____ State _____ Zip Code _____

Home Phone ____ - ____ - ____ Work Phone ____ - ____ - ____

Mother / Guardian (Name) _____

Street _____

City _____ State _____ Zip Code _____

Home Phone ____ - ____ - ____ Work Phone ____ - ____ - ____

Contact in Case of Emergency (If married, please list spouse as contact)

Name _____

Home Phone ____ - ____ - ____ Work Phone ____ - ____ - ____

GENERAL MEDICAL HEALTH HISTORY

Do you have or have you EVER had any of the following medical conditions?

| | Y E S | N O | | Y E S | N O |
|---------------------------------|-------|-----|-------------------------------|-------|-----|
| High Blood Pressure | | | Asthma | | |
| Rheumatic Heart Disease | | | Exercise Induced Asthma | | |
| Rheumatic Fever | | | Sinus Infection | | |
| Pericarditis | | | Nasal Polyps | | |
| Any Hearth Disease | | | Nose Fracture | | |
| Tumor, Growth, Cyst, Cancer | | | Seizure Disorder/Epilepsy | | |
| Any Ruptured Organs | | | Meningitis | | |
| Hepatitis | | | Migraine Headaches | | |
| Jaundice | | | Amnesia | | |
| Sickle Cell Anemia/Carrier | | | Goiter, Thyroid Disease | | |
| Pleurisy | | | Skin Disease | | |
| Pneumonia | | | Diabetes | | |
| Polio | | | Anemia | | |
| Bronchitis | | | Abnormal Bruising | | |
| Tuberculosis | | | Abnormal Bleeding | | |
| Frequent Respiratory Infections | | | Gastrointestinal Bleeding | | |
| Malaria | | | Blood Disease | | |
| Mumps | | | Blood Clots | | |
| Mononucleosis | | | Kidney Disease | | |
| Rubella | | | Kidney Injury | | |
| Red Measles/Rubeola | | | Kidney Stones | | |
| Chicken Pox | | | Urinary Infections | | |
| Arthritis | | | Blood in Urine | | |
| Ear Infection | | | Joint Inflammation | | |
| Hearing Defect/Loss | | | Herpes (Oral) | | |
| Muscular Disease | | | Herpes (Genital) | | |
| Stomach Ulcer (Peptic) | | | Sexually Transmitted Diseases | | |
| Birth Defects | | | Hernia | | |
| Appendicitis | | | Car or Air Sickness | | |
| Gout | | | Constipation | | |
| Constipation | | | Hemorrhoids | | |

Are you CURRENTLY experiencing any of the following SYMPTOMS or PROBLEMS?

| | Y E S | N O | | Y E S | N O |
|----------------------------|-------|-----|----------------------------|-------|-----|
| Ongoing or Chronic Illness | | | Skin Problem | | |
| Frequent Headaches | | | Abdominal Pain | | |
| Visual Changes | | | Muscle Cramps | | |
| Ear Pain/ Hearing Changes | | | Nausea, Vomiting, Diarrhea | | |
| Sore Throat | | | Penile Discharge | | |
| Sinus Congestion | | | Vaginal Discharge | | |
| Breathing Difficulty | | | Rectal Bleeding | | |
| Recurring Coughing | | | Unusual Fatigue | | |
| Chest Pain | | | Blood in Urine | | |

GENERAL MEDICAL HEALTH HISTORY

| Has any blood relative ever had.... | YES | NO | WHO ? |
|-------------------------------------|-----|----|-------|
| Sudden Death (before age 55) | | | |
| Blood Diseases | | | |
| Sickle Cell or Leukemia | | | |
| Diabetes | | | |
| Epilepsy | | | |
| Gout | | | |
| Heart Disease | | | |
| Hemophilia | | | |
| High Blood Pressure | | | |
| Neurological Disorders | | | |
| Stroke | | | |
| Tuberculosis | | | |
| Asthma | | | |
| Glaucoma | | | |

MENTAL HEALTH HISTORY

| | Ever Diagnosed | Ever Treated | Ever Taken Medication | Date |
|--------------------------------|----------------|--------------|-----------------------|------|
| Attention Deficient Disorder | | | | |
| Depression / Unipolar | | | | |
| Bipolar / Manic Depression | | | | |
| Seasonal Affective Disorder | | | | |
| Anxiety Disorder | | | | |
| Panic Attacks | | | | |
| Phobias | | | | |
| Personality Disorder | | | | |
| Paranoia | | | | |
| Obsessive Compulsive Disorder | | | | |
| Post Traumatic Stress Disorder | | | | |
| Psychotic | | | | |
| Schizophrenia | | | | |
| Suicide Attempt | | | | |
| Thoughts of suicide | | | | |
| Eating Disorder | | | | |

Are you currently being treated for any of the above conditions? If yes, please explain.

Are you currently taking medication for any of the above conditions? If yes, please explain.

Please list all medications and frequency of use.

HEAD INJURY HISTORY

| | YES | NO | DATE |
|--|-----|----|------|
| Unconscious | | | |
| Dazed/Dizzy | | | |
| Knocked Out | | | |
| Concussion | | | |
| Headaches - Frequent or Severe | | | |
| Memory Loss Have you ever had a seizure? Did you have other memory problems afterward (anterograde amnesia) Did you lose your memory of the vent or circumstances prior to the event (retrograde amnesia) | | | |
| Fractures | | | |
| X-Rays, CT Scan, MRI | | | |
| Hospitalized | | | |
| Surgery | | | |
| Missed practices: # | | | |
| Missed games: # | | | |
| Other | | | |

Comments:

CARDIAC/HEART HISTORY

| | YES | NO |
|--|-----|----|
| Have you ever had shortness of breath during or after exercise? | | |
| Have you ever felt dizzy, light-headed or passed out during or after exercise? | | |
| Have you ever had chest pain while during or after exercising? | | |
| Have you ever had racing of your heart or skipped heartbeats? | | |
| Have you ever had irregular heart beats, heart palpitations or arrhythmia? | | |
| Have you had high blood pressure or high cholesterol? | | |
| Have you ever been told you have a heart murmur? | | |
| Have you ever been seen by a heart specialist (cardiologist) ? If yes, who? Date? | | |
| Have you ever had an echocardiogram? | | |
| Have you ever had a stress (heart) exam? | | |
| Do you get tired more quickly than your friends do during exercise? | | |
| Has any family member or relative died of heart problems or a sudden death before age 50? | | |
| Have you had a severe viral infection (myocarditis or mononucleosis) within the last month? | | |
| Has a physician ever denied or restricted your participation in sports for any heart problems? | | |
| Has a physician ever placed you on medication for your heart or high blood pressure? | | |

Comments:

VISION INFORMATION

| | YES | NO |
|--|-----|----|
| Have you had any problems with your eyes or vision? | | |
| Have you ever been to an eye doctor? | | |
| Do you wear glasses now? | | |
| If yes, reading only? | | |
| Distance only? | | |
| All the time? | | |
| Do you wear contacts? | | |
| If yes, soft lenses? | | |
| Hard lenses? | | |
| Do you have a second pair of contacts? | | |
| Do you wear contact lenses / glasses to participate in your sport? | | |
| Have you ever had an eye injury? | | |
| Date: Explain: | | |
| Is your color vision normal? | | |
| Have you ever worn a false eye? | | |

Date of last eye exam: ___/___/___ Physician's Name: _____

Prescription: Right: _____ Left: _____

DENTAL INFORMATION

Date of last dental visit _____/_____/_____

| | YES | NO |
|---|-----|----|
| Do you have a bridge or false teeth? | | |
| Have you ever fractured a tooth? | | |
| Have you had a tooth knocked out? | | |
| Do you wear a mouth protector? | | |
| Do you wear orthodontic appliances? | | |
| Have you had your wisdom teeth removed? | | |
| If yes, Date: | | |

Comments:

HEAT ILLNESS OR HEAT RELATED PROBLEMS

| HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? | Y E S | N O |
|--|--------------|------------|
| Become ill from exercising in the heat? | | |
| Trouble with dehydration (excessive loss of salt and water)? | | |
| Heat exhaustion or stroke? | | |
| Heat cramps (due to fluid loss in excessive heat) ? | | |
| Have you ever been hospitalized for heat illness? | | |

Comments:

ALLERGIES

| ARE YOU ALLERGIC TO....? | Y E S | N O |
|---|--------------|------------|
| Insect bites / stings | | |
| Aspirin | | |
| Codeine | | |
| Cortisone | | |
| Sulfa | | |
| Anti-inflammatory | | |
| Penicillin | | |
| Antibiotics | | |
| Tetanus Antitoxin or Serums | | |
| Nail Polish or Cosmetics | | |
| Any other drugs | | |
| Any Foods | | |
| Pollens, trees, grasses | | |
| Other: | | |
| Have you ever had a rash or hives develop during or after exercise? | | |

Comments:

MISCELLANEOUS HEALTH HISTORY INFORMATION

| Have you ever...? | Y E S | N O |
|--|--------------|------------|
| Been Hospitalized? | | |
| Worn hearing aids? | | |
| Stuttered or stammered? | | |
| Coughed up blood? | | |
| Bled excessively after injury? | | |
| Been advised to have any operations? | | |
| Had Surgery? | | |
| Do you have any pins, staple, or wires in any part of your body? | | |
| Had any illnesses other than those already noted? | | |
| Have you ever missed a game because of illness? | | |

Comments:

DRUG, FOOD SUPPLEMENTS AND MISCELLANEOUS AGENTS

Check the appropriate space according to YOUR use of the following items:

| | NEVER | RARELY | OCCASIONALLY | FREQUENTLY |
|---------------------|-------|--------|--------------|------------|
| Inhaler | | | | |
| Vitamins | | | | |
| Diet Pills | | | | |
| Sleeping Pills | | | | |
| Laxatives | | | | |
| Alcoholic Beverages | | | | |
| Antihistamines | | | | |
| Allergy Medicine | | | | |
| Anti-Inflammatories | | | | |
| Aspirin | | | | |
| Ibuproen | | | | |
| Caffeine | | | | |
| Tobacco | | | | |
| Other Drugs: | | | | |
| Steroids | | | | |
| Amino Acids | | | | |
| Protein Supplements | | | | |

Are you currently taking any prescription or non-prescription medication or pills:

INTERNAL MEDICAL HISTORY

To your knowledge, **were you born with a complete** and functional set of paired organs?

| | YES | NO | REPAIRED | REMOVED |
|-------------------|-----|----|----------|---------|
| Eyes | | | | |
| Ears | | | | |
| Kidneys | | | | |
| Ovaries/Testicles | | | | |
| Lungs | | | | |

Have you ever had **surgery to repair or remove** any organ?

| | YES | NO | REPAIRED | REMOVED |
|-----------|-----|----|----------|---------|
| Hernia | | | | |
| Testicles | | | | |
| Appendix | | | | |
| Spleen | | | | |
| Kidney | | | | |
| Other | | | | |

Physician: _____ Physician's Address: _____

WOMEN'S HEALTH HISTORY

For female athletes only; males proceed to the next page.

| | Y E S | N O |
|--|-------|-----|
| How many periods have you had in the last year? | | |
| What was the longest time between periods in the last year? | | |
| Are your periods regular? | | |
| Age of onset: _____ | | |
| Date of last period: ____/____/____ | | |
| Interval between periods: _____ | | |
| Duration of periods: _____ | | |
| Is flow heavy? | | |
| Is heavy bleeding ever a problem? | | |
| Do you ever have bleeding between periods? | | |
| Do you experience any unusual discharge? | | |
| Are cramps a frequent problem during your period? | | |
| Any past pregnancies/births? | | |
| Do you use oral contraceptives? If yes, what brand name? _____ | | |
| Do you do monthly breast self-examinations? | | |
| Do you have frequent urinary tract infections? | | |
| Have you ever had a gynecological exam? Date of last exam? ____/____/____ | | |
| Have you ever had a pap smear? Date of last pap smear? ____/____/____ | | |
| Have you ever had an abnormal pap smear? | | |
| Do you wish to see a dietician? | | |
| | | |

Comments:

ORTHOPEDIC HEALTH HISTORY

Please place a check in either the “yes” or “no” box.

NECK INJURY HISTORY

| | YES | NO | DATE | R | L |
|--|-----|----|------|---|---|
| Strained muscle | | | | | |
| Sprained ligament | | | | | |
| Swelling | | | | | |
| Stretches | | | | | |
| Pinched Nerve | | | | | |
| Disk Injury | | | | | |
| Dislocations | | | | | |
| Burners / Stingers | | | | | |
| Injections | | | | | |
| Pains | | | | | |
| Fractures | | | | | |
| X-Rays, CT Scans, MRI | | | | | |
| Hospitalized | | | | | |
| Surgery | | | | | |
| Missed Practices: # | | | | | |
| Missed Games: # | | | | | |
| Other | | | | | |
| Numbness or tingling in your arms, hands, legs, etc. | | | | | |
| Do you wear a neck roll (FOOTBALL ONLY) | | | | | |

Comments:

CHEST WALL HISTORY

| | YES | NO | DATE | R | L |
|------------------------------------|-----|----|------|---|---|
| Fractured collar bone | | | | | |
| Sterno-clavicular joint separation | | | | | |
| Fractured / bruised ribs | | | | | |
| Costalchondritis | | | | | |
| Pneumothorax | | | | | |
| Sternal injury | | | | | |
| Bruise | | | | | |
| Swelling | | | | | |
| Pains | | | | | |
| X-Rays, CT Scans, MRI | | | | | |
| Hospitalized | | | | | |
| Surgery | | | | | |
| Missed Practices: # | | | | | |
| Missed games: # | | | | | |
| Other: | | | | | |

Comments:

MID BACK HISTORY

| | YES | NO | DATE | R | L |
|----------------------|-----|----|------|---|---|
| Strained muscle | | | | | |
| Sprained ligament | | | | | |
| Swelling | | | | | |
| Nerve pinches | | | | | |
| Disk Injury | | | | | |
| Spondylolisthesis | | | | | |
| Scoliosis | | | | | |
| Abnormal kyphosis | | | | | |
| Referred pain | | | | | |
| Pain down leg | | | | | |
| Numbness in leg | | | | | |
| Weakness in leg | | | | | |
| Bruise | | | | | |
| Injections | | | | | |
| Pains | | | | | |
| Fractures | | | | | |
| X-rays, CT Scan, MRI | | | | | |
| Hospitalized | | | | | |
| Surgery | | | | | |
| Missed practices: # | | | | | |
| Missed games: # | | | | | |
| Other | | | | | |

Comments:

LOWER BACK HISTORY

| | YES | NO | DATE | R | L |
|---------------------------|-----|----|------|---|---|
| Strained muscle | | | | | |
| Sprained ligament | | | | | |
| Swelling | | | | | |
| Nerve pinches | | | | | |
| Disc injury | | | | | |
| Sacroiliac joint disorder | | | | | |
| Referred pain | | | | | |
| Pain down leg | | | | | |
| Numbness in leg | | | | | |
| Weakness in leg | | | | | |
| Bruise | | | | | |
| Injections | | | | | |
| Pains | | | | | |
| Fracture | | | | | |
| X-rays, CT Scan, MRI | | | | | |
| Hospitalized | | | | | |
| Surgery | | | | | |
| Missed practices: # | | | | | |
| Missed games: # | | | | | |

Comments:

PELVIS / HIPS HISTORY

| | YES | NO | DATE | R | L |
|----------------------|-----|----|------|---|---|
| Strained muscle | | | | | |
| Sprained ligament | | | | | |
| Swelling | | | | | |
| Groin pulls | | | | | |
| Dislocations | | | | | |
| Casted | | | | | |
| Bruise | | | | | |
| Injections | | | | | |
| Pains | | | | | |
| Fractures | | | | | |
| X-rays, CT Scan, MRI | | | | | |
| Hospitalized | | | | | |
| Surgery | | | | | |
| Missed practices: # | | | | | |
| Missed games: # | | | | | |
| Other | | | | | |

Comments:

SHOULDER HISTORY

| | YES | NO | DATE | R | L |
|------------------------------|-----|----|------|---|---|
| Strained muscle | | | | | |
| Sprained ligament | | | | | |
| Swelling | | | | | |
| A-C separations | | | | | |
| Dislocations | | | | | |
| Partial dislocations | | | | | |
| Shoulder slips out of place | | | | | |
| Rotator cuff injury | | | | | |
| Impingement | | | | | |
| Tendinitis | | | | | |
| Bursitis | | | | | |
| Bruise | | | | | |
| Injections | | | | | |
| Pain w/ overhead activity | | | | | |
| Arm goes "dead" after trauma | | | | | |
| Fractures | | | | | |
| X-rays, CT Scan, MRI | | | | | |
| Hospitalized | | | | | |
| Surgery | | | | | |
| Missed practices: # | | | | | |
| Missed games: # | | | | | |
| Other | | | | | |

Comments:

UPPER ARM & FOREARM HISTORY

| | YES | NO | DATE | R | L |
|----------------------|-----|----|------|---|---|
| Strained muscle | | | | | |
| Swelling | | | | | |
| Calcium deposits | | | | | |
| Casted | | | | | |
| Bruised | | | | | |
| Injections | | | | | |
| Numbness in fingers | | | | | |
| Pains | | | | | |
| Fractures | | | | | |
| X-rays, CT Scan, MRI | | | | | |
| Hospitalized | | | | | |
| Surgery | | | | | |
| Missed practices: # | | | | | |
| Missed games: # | | | | | |
| Other | | | | | |

Comments:

ELBOW HISTORY

| | YES | NO | DATE | R | L |
|----------------------|-----|----|------|---|---|
| Strained muscle | | | | | |
| Sprained ligament | | | | | |
| Swelling | | | | | |
| Bursitis | | | | | |
| Dislocations | | | | | |
| Joint Locking | | | | | |
| Casted | | | | | |
| Tendinitis | | | | | |
| Bruise | | | | | |
| Swelling | | | | | |
| Injections | | | | | |
| Pains | | | | | |
| Fractures | | | | | |
| X-rays, CT Scan, MRI | | | | | |
| Hospitalized | | | | | |
| Surgery | | | | | |
| Missed practices: # | | | | | |
| Missed games: # | | | | | |
| Other: | | | | | |

Comments:

WRIST HISTORY

| | YES | NO | DATE | R | L |
|----------------------|-----|----|------|---|---|
| Strained muscle | | | | | |
| Sprained ligament | | | | | |
| Swelling | | | | | |
| Tendonitis | | | | | |
| Dislocations | | | | | |
| Casted | | | | | |
| Bruise | | | | | |
| Cyst | | | | | |
| Injections | | | | | |
| Pains | | | | | |
| Fractures | | | | | |
| X-rays, CT Scan, MRI | | | | | |
| Hospitalized | | | | | |
| Surgery | | | | | |
| Missed Practices: # | | | | | |
| Missed Games: # | | | | | |
| Other: | | | | | |

Comments:

HAND HISTORY

| | YES | NO | DATE | R | L |
|----------------------|-----|----|------|---|---|
| Strained muscle | | | | | |
| Sprained ligament | | | | | |
| Swelling | | | | | |
| Dislocations | | | | | |
| Casted / Splinted | | | | | |
| Bruise | | | | | |
| Cyst | | | | | |
| Injections | | | | | |
| Pains | | | | | |
| Fractures | | | | | |
| X-rays, CT Scan, MRI | | | | | |
| Hospitalized | | | | | |
| Surgery | | | | | |
| Missed practices: # | | | | | |
| Missed games: # | | | | | |
| Other: | | | | | |

Comments:

FINGER & THUMB HISTORY

| | YES | NO | DATE | R | L |
|----------------------|-----|----|------|---|---|
| Strained muscle | | | | | |
| Sprained ligament | | | | | |
| Swelling | | | | | |
| Dislocations | | | | | |
| Casted | | | | | |
| Bruise | | | | | |
| Cyst | | | | | |
| Injections | | | | | |
| Pains | | | | | |
| Fractures | | | | | |
| X-rays, CT Scan, MRI | | | | | |
| Hospitalized | | | | | |
| Surgery | | | | | |
| Missed practices: # | | | | | |
| Missed games: # | | | | | |
| Other: | | | | | |

Comments:

THIGH HISTORY

| | YES | NO | DATE | R | L |
|----------------------|-----|----|------|---|---|
| Strained muscle | | | | | |
| Sprained ligament | | | | | |
| Swelling | | | | | |
| Quad pulls | | | | | |
| Hamstring pulls | | | | | |
| IT Band Syndrome | | | | | |
| Calcium deposits | | | | | |
| Bruise | | | | | |
| Injections | | | | | |
| Pains | | | | | |
| Fractures | | | | | |
| X-rays, CT Scan, MRI | | | | | |
| Hospitalized | | | | | |
| Surgery | | | | | |
| Missed practices: # | | | | | |
| Missed games: # | | | | | |
| Other: | | | | | |

Comments:

LOWER LEG HISTORY

| | YES | NO | DATE | R | L |
|----------------------------------|-----|----|------|---|---|
| Strained muscle | | | | | |
| Sprained ligament | | | | | |
| Swelling | | | | | |
| Shin splints | | | | | |
| Bursitis | | | | | |
| Bruise | | | | | |
| Injections | | | | | |
| Painful – tight calf w/ activity | | | | | |
| Achilles tendon injury | | | | | |
| Stress fracture | | | | | |
| Fractures | | | | | |
| X-rays, CT Scan, MRI | | | | | |
| Hospitalized | | | | | |
| Surgery | | | | | |
| Missed practices: # | | | | | |
| Missed games: # | | | | | |
| Other | | | | | |

Comments:

ANKLE HISTORY

| | YES | NO | DATE | R | L |
|----------------------|-----|----|------|---|---|
| Strained muscle | | | | | |
| Sprained ligament | | | | | |
| Swelling | | | | | |
| Dislocations | | | | | |
| Casted / splinted | | | | | |
| Bruise | | | | | |
| Instability | | | | | |
| Giving out | | | | | |
| Weakness | | | | | |
| Injections | | | | | |
| Pains | | | | | |
| Fractures | | | | | |
| X-rays, CT Scan, MRI | | | | | |
| Hospitalized | | | | | |
| Surgery | | | | | |
| Missed practices: # | | | | | |
| Missed games: # | | | | | |
| Other: | | | | | |

Comments:

KNEE HISTORY

| | YES | NO | DATE | R | L |
|---------------------------|-----|----|------|---|---|
| Strained muscle | | | | | |
| Sprained ligament | | | | | |
| Swelling | | | | | |
| Torn ligaments | | | | | |
| Torn cartilage | | | | | |
| Knee cap injury | | | | | |
| Knee cap dislocation | | | | | |
| Osgood Schlatter's | | | | | |
| Bursitis | | | | | |
| Swelling | | | | | |
| Locking | | | | | |
| Giving away | | | | | |
| Sudden weakness, shifting | | | | | |
| Wear braces | | | | | |
| Casted | | | | | |
| Arthritis | | | | | |
| Chondromalacia | | | | | |
| Grinding | | | | | |
| Tendinitis | | | | | |
| Jumper's knee | | | | | |
| Bruise | | | | | |
| Injections | | | | | |
| Pains | | | | | |
| Pain w/stairs | | | | | |
| Pain w/ squats | | | | | |
| Arthrograms | | | | | |
| Fractures | | | | | |
| X-rays, Ct Scan, MRI | | | | | |
| Hospitalized | | | | | |
| Surgery | | | | | |
| Missed practices: # | | | | | |
| Missed games: # | | | | | |
| Other: | | | | | |

Comments:

FOOT & TOE HISTORY

| | YES | NO | DATE | R | L |
|----------------------|-----|----|------|---|---|
| Strained muscle | | | | | |
| Sprained ligament | | | | | |
| Swelling | | | | | |
| Turf toe | | | | | |
| Plantar fasciitis | | | | | |
| Bunions | | | | | |
| Dislocations | | | | | |
| Casted / Splinted | | | | | |
| Bruise | | | | | |
| Injections | | | | | |
| Fractures | | | | | |
| X-rays, CT Scan, MRI | | | | | |
| Hospitalized | | | | | |
| Surgery | | | | | |
| Missed practices: # | | | | | |
| Missed games: # | | | | | |
| Other | | | | | |

Comments:

MISCELLANEOUS HISTORY

| | YES | NO |
|---|-----|----|
| Have you had or do you have any other medical problems or injuries not listed on this form? | | |
| Do you have any medical or health problems that you are currently receiving medical treatment for? | | |
| Is there any reason that you are not able to participate in athletics? | | |
| Are there any additional health problems you would prefer to discuss privately with our team physician? | | |

If any of the above questions were answered yes, please comment:

List any special protective equipment you require or would like to have provided:

The undersigned, herewith,

- A. Understands that he/she must refrain from practice or play during medical treatment until he/she is discharged from treatment or given a written permit by the attending physician to resume participation.
- B. Certifies that the answers to these questions are correct and true.
- C. Understands that his/her having passes the physical examination does not necessarily mean that he/she is physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify him/her.
- D. Fully realizes the University of Nevada, Las Vegas cannot be held responsible for any previous medical condition (s) that he/she might have.
- E. Understands permission to practice will not be granted until these forms are completed and signed by an athletic trainer.

Name: (Please Print) _____

Date: ____/____/____

Signature

If under 18 years of age, please have
signed by a parent or guardian.

Signature

| |
|--|
| Upon completion of this Medical History Form, it will be reviewed and signed by a Staff AthleticTrainer. Signature: _____ A.T.C., Date: _____ |
|--|

PLEASE READ THE FOLLOWING CONSENT FORMS CAREFULLY

(If you are under 18 years of age, your parents must also sign these forms)

The basic content of each form is as follows:

1. Shared Responsibility for Sport Safety: Acknowledges that there are certain inherent risks involved in participating in intercollegiate athletics and that you are willing to assume responsibility for such risks.
2. Release of Info to NCAA, Conference, Media & Professional Teams Allows those listed to release any and all information concerning you, including records and other items listed, to the NCAA, Conference, Media & Professional teams.
3. Notice of Privacy Practices: How your health information may be used and disclosed by the University of Nevada, Las Vegas and your rights pertaining to that information.
4. Consent for Medical Treatment and Disclosure: Allows the athletic trainers and physicians to treat any injury you receive while at the University of Nevada, Las Vegas.
5. AIDS & Hepatitis Acknowledges that HIV and Hepatitis transmission is possible through athletics.

If you choose to refuse to sign any of these forms please write “Refuse to Sign”, the date and your signature.

SHARED RESPONSIBILITY FOR SPORTS SAFETY - PART 1

Participation in sport requires an acceptance of risk of injury. Athletes rightfully assume that those who are responsible for the conduct of sport have taken reasonable precaution to minimize such risk and their peers participating in sport will not intentionally inflict injury upon them.

Periodic analysis of injury patterns and refinements in the rules and other safety decisions is an ongoing process. However to legislate safety via a rule book and equipment standards, while often necessary, seldom is effective by itself; and to rely on officials to enforce compliance with safety guidelines is as insufficient as to rely on warning labels to produce compliance with safety guidelines. “Compliance” means respect on everyone’s part for the intent and purpose of a rule or guideline.

I understand that by voluntarily participating in athletics at the collegiate level, I am undertaking a non-controllable risk may result in an injury that may be severe in nature. Such an injury may result in permanent paralysis and/or death.

I understand sickness and/or injuries are common in all athletics and that the University of Nevada, Las Vegas Intercollegiate Athletic Department will provide the most reasonable medical coverage in order to reduce the severity of such illness and /or injury. The administration, coaches, athletic trainers, and equipment specialists will equally provide to each student the necessary equipment and/or protective devices required to produce the safest possible intercollegiate athletic environment regardless of age, sex, race, or religion.

Pertains to football only - I have read the following:

WARNING: Do not use this helmet to butt, ram, or spear opposing players. This is a violation of the football rules and can result in severe head, brain or neck injury, paralysis or death to you and possible injury to your opponent. There is a risk that injuries may occur as a result of accidental contact without intent to butt, ram, or spear. **NO HELMET CAN PREVENT ALL SUCH INJURIES.** (This information can be found inside each and every issued helmet and should be read daily.)

I have been instructed on all issued equipment and protective devices that are standards of the NCAA rules.

I have read the above shared responsibility statement. I understand there are certain inherent risks involved in participating in intercollegiate athletics. I acknowledge the fact these risks exist and I am willing to assume responsibility for such risks while participating at the University of Nevada, Las Vegas.

Student-Athlete Signature: _____

Date: _____

If student-athlete is a minor:

Student-Athlete Representative Signature: _____

Date: _____

Description of Legal Guardianship: _____

RELEASE OF INFORMATION TO THE NCAA, CONFERENCE, MEDIA & PROFESSIONAL TEAMS – PART 2

I, _____, hereby authorize _____
Name of Student Athlete Name of My Institution

and its coaches, physicians, athletic trainers and health care personnel to disclose my protected health information and any related information regarding any injury or illness during my training for, and participation in, intercollegiate athletics to the NCAA, my institution's athletic conference, to media outlets, to professional sports teams, and to their respective employees or agents.

I understand that my protected health information will be used by the NCAA, Conference, media, and/or professional sports teams for the purpose of statistical reporting, providing to the public information regarding the general type of any injury or illness that I have incurred, the medical professionals involved in my care, the current status of my health, and my probable return date to active participation, and providing professional sports teams with information for player evaluation purposes.

I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I understand that my signing of this authorization/consent is voluntary and that my institution will not condition any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the consent/authorization requested. I also understand that I am

not required to sign this authorization/consent in order to be eligible to participate in NCAA or conference athletics.

I also understand that the NCAA, Conference, media, and professional teams may not be covered by the Buckley Amendment or HIPAA and that these regulations may not apply to their use or disclosure of my injury/illness information.

This authorization/consent expires 380 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the athletic director at my institution. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization/consent.

| | | |
|---------------------------------|-----------|------|
| Printed Name of Student Athlete | Signature | Date |
|---------------------------------|-----------|------|

If under age 18:

| | |
|--|------|
| Signature of Parent or Guardian (identify which) | Date |
|--|------|

Description of Legal Guardianship: _____

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|---|
| NOTICE OF PRIVACY PRACTICES (effective August 1, 2003) |
|---|

This notice describes how your health information may be used and disclosed by the University of Nevada, Las Vegas Athletic Training Department and your rights pertaining to that information. Please review it carefully.

UNDERSTANDING YOUR PATIENT HEALTH INFORMATION (PHI)

Understanding what is in your health record and how your health information is used will help you to ensure its accuracy, allow you to better understand who, what, where and why others may access your health information, and assist you in making more informed decisions when authorizing disclosure to others. When you visit us, we keep a record of your symptoms, examination, test results, diagnoses, treatment plan, and other medical information. We also may obtain health records from other providers. In using and disclosing your protected health information, it is our objective to follow the Privacy Standards of the federal Health Insurance Portability and Accountability Act, 45 CFR Part 464, even if this is not required in order to treat students. The law allows us to use and disclose your health information without your specific authorization for treatment, payment and operations and other specific purposes explained on the next page. This includes the sharing of information, when necessary and appropriate, with other health care components of the University, such as the athletic department, student health center or the counseling center, as necessary for your continued care. All other uses and disclosures require your specific authorization.

YOUR HEALTH INFORMATION RIGHTS You have a right to:

- Request a restriction on the uses and disclosures of your protected health information as described in this notice, although we are not required to agree to the restriction you request. You should address your request in writing to the designated Privacy Officer. We will notify you within 30 days if we cannot agree to the restriction.
- If you received the Notice of Privacy Practices electronically, you may request a paper copy of the Notice.
- Upon written request, you may inspect and obtain a copy of your health record for a fee of \$.60 per page and the actual cost of postage per **NRS 629.061**, except that you are not entitled to access to, or to obtain a copy of, psychotherapy notes and information compiled for legal proceedings.
- Amend your health record by submitting a written request with the reasons supporting the request to the Privacy Officer. In most cases, we will respond within 30 days. We are not required to agree to the requested amendment.
- Obtain an accounting of disclosures of your health information, except that we are not required to account for disclosures for treatment, payment, operations, or pursuant to authorization, among other exceptions.

- Send and receive confidential communications of protected health information by alternative means or at alternative location, other than our usual methods. You should address the request in writing to the designated Privacy Officer.
- Revoke an authorization to use or disclose health information at any time except where action has already been taken.

RESPONSIBILITIES OF THE UNLV ATHLETIC TRAINING DEPARTMENT We are required by law to:

- Maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to your protected health information.
- Abide by the terms of the notice currently in effect. We have the right to change our notice of privacy practices and apply the change to all of your protected health information, including information obtained prior to the change.
- If we change our notice of privacy practices, we will post the new changes in the lobby and a copy will be available to you upon request.
- Use or disclose your health information only with your authorization except as described in this notice.
- In some circumstance, state or federal law may prohibit or further restrict the disclosure of your health information. If that is the case, we are required to follow the more stringent law.

FOR MORE INFORMATION OR TO REPORT A PROBLEM, you may contact the designated Privacy Officer, the Director of Athletic Training at (702) 895-3380. If you feel your rights have been violated, you may file a complaint in writing with the designated Privacy Officer. If you are not satisfied with the resolution of the complaint, you may also file a complaint with the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We may use or disclose your protected health information for treatment, payment and operations, and for purposes described below:

We will use your health information for treatment: e.g. we will use information obtained by a physician, nurse practitioner, nurse or other medical professionals, staff, trainees and volunteers in our office to determine your best course of treatment. The information obtained from you or from other providers will become part of your medical records. We may also disclose your health care information to other outside treating medical professionals and staff as deemed necessary for your care. For example, we may disclose your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist him/her in your treatment. We will disclose personal health information to coaches pertaining to your current medical condition and any conditions that may restrict your ability to compete.

We will use your health information for payment: e.g. we may send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used as necessary to obtain payment.

We will use your health information for regular health operations: e.g. members of the medical staff, trainees, medical students, a Risk or Quality Improvement team, or similar internal operations may use your information to assess the care and outcomes of your care in an effort to improve the quality of the healthcare and service we provide or for educational purposes. For example, an internal review team may review your medical records to determine the appropriateness of care. There may also be times in which our accountants, auditors or attorneys may be required to review your health information to meet their responsibilities.

Other uses and disclosures not requiring authorization

- Business Associates: There are some services provided in our organization through contracts with business associates, such as laboratory services and radiology services. We may disclose your health information to our business associate so that they can perform these services. To protect your health information, we require the business associate to appropriately safeguard your information.
- Notification: We may disclose your health information to a friend or family member involved in your care or assisting you in payment. We may also notify a family member, friend, or other person responsible for your care, about your location and general condition.

- Disclosures required by law or for threats to safety: We may disclose your health information as required by law, or if necessary to avert a serious threat to health or safety, although disclosures are limited if information is obtained through counseling or therapy.
- Public Health: As allowed by law, we may disclose your health information to public health or legal authorities to 1) prevent or control disease, injury or disability, 2) to report child abuse or domestic abuse, in which case you may be notified of the disclosure, 3) for purposes related to quality, safety, or effectiveness of FDA-regulated products or activity, 4) to identify exposure to, and prevent the spread of, communicable disease, including notification of individuals that may have been exposed to communicable disease, 5) to an employer to conduct medical surveillance of the workplace or to evaluate whether an employee has a work related illness or injury, 6) to health oversight agencies as provided by law and 7) to report births and deaths..
- Law Enforcement and Court Proceedings: We may disclose health information to law enforcement in the following circumstances 1) information required by law, 2) limited information for identification and location purposes, 3) information regarding suspected victims of crime, although we will usually attempt to first obtain your agreement to release the information, 4) information about a deceased individual if we have a suspicion that the death resulted from criminal conduct, 5) information that we believe in good faith establishes that a crime has been committed on our premises during our providing of emergency health care. We may also disclose health information to others as required by court or administrative order, or in response to a valid summons or subpoena, for civil subpoenas, we will seek assurances from the requesting party that reasonable efforts have been made to inform you of the subpoena.
- Information Regarding Decedents: We may disclose health information regarding a deceased person to: 1) coroners and medical examiners to identify cause of death or other duties, 2) funeral directors for their required duties and 3) to procurement organizations for purposes of organ and tissue donation.
- Research: We may disclose health information to where you have authorized such disclosure. We may also disclose health information where the disclosure is solely for the purpose of designing a study, or where the disclosure concerns decedents, or the disclosure is approved by an institutional review board (IRB) or properly constituted Privacy Board if the Board has determined that obtaining authorization is not feasible and protocols are in place to ensure the privacy of your health information.
- Military, National Security and Correctional Department Disclosures: We may disclose health information in connection with the responsibilities of the armed services if you are a member, national security and intelligence, protective services for certain government officials, and to correctional officials for health and safety purposes if you are an inmate.
- Marketing and Appointment Reminders: We may contact you to providee appointment reminders or information about treatment alternative or other health related benefits and services that may be of interest to you.
- Fund raising: We may contact you as part of a fund raising effort.

Disclosures requiring authorization: All other disclosures of protected health information will only be made pursuant to your written authorization, which you have the right to revoke at any time, except to the extent we have already relied upon the authorization.

Federal law requires that we seek your acknowledgement of receipt of this Notice of Privacy Practices. Please sign below.

I acknowledge that I have received this Notice of Privacy Practices with and effective date of _____

Student-Athlete Signature: _____

Date: _____

If student-athlete is a minor:

Student-Athlete Representative Signature: _____

Date: _____

Description of Legal Guardianship: _____

CONSENT FOR MEDICAL TREATMENT & DISCLOSURES- PART 4

CONSENT FOR MEDICAL TREATMENT AND USES AND DISCLOSURES OF PATIENT HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS (TPO) AT THE UNIVERSITY OF NEVADA, LAS VEGAS

I give my permission to the University of Nevada, Las Vegas to educate, interview, examine, perform laboratory procedures and to treat my condition, as they deem necessary. I understand that in case of a life-threatening emergency, this consent may be implied for the time of the emergency.

I understand that the University of Nevada, Las Vegas is a teaching institution, therefore athletic training students, medical residents, medical students, dental students, nurse practitioner students and nursing students may participate in my care under the supervision of a certified athletic trainer, physician/dentist or nurse practitioner. I understand that other outside medical professionals may also be consulted as deemed necessary for my care.

For coordination of my care and services, I understand that I may be provided with referrals to off campus specialists and the University of Nevada, Las Vegas may assist other treating physicians/dentists in provision of my care.

- **Informed Consent:** If my condition requires an outpatient surgical procedure, the practitioner responsible for my care will explain to me the procedure to be performed, the general nature and extent of risks involved in such procedure and the alternative methods, if any.
- **Consent for Minor Students:** If you are a minor, we must have the signature of the parent or legal guardian (appointed by a court of law) on this form before any general treatment may begin, and such consent must be effective until you reach legal age in the State of Nevada (18 years old). Your parent or legal guardian must sign this consent form and receive a Notice of Privacy.
 - ◆ **Exemptions to this consent are** a life-threatening emergency, treatment for emancipated minors with court supporting documents and per **NRS 442.255** and **NRS 129.060** for family planning and contraceptive methods, screening for sexually transmitted infections, counseling and treatment of alcohol and substance abuse.
- **Additional Uses and Disclosures of Health Information:** I understand and agree that the University of Nevada, Las Vegas may use or disclose protected health information for treatment, payment and operations in accordance with the Notice of Privacy Practices that I have received, and any posted amendments to that Notice. I understand that the University of Nevada, Las Vegas will not use or disclose protected health information for any purpose other than treatment, payment and healthcare operations, unless such person or entity is authorized to receive such information under law or I have provided a written authorization. (*See full explanation of disclosures and rights in the Notice of Privacy Practices*) If I am being treated while I am a student, I consent and agree that my health information may be used and disclosed in accordance with the Notice of Privacy (and any posted revision of that Notice) and the federal Health Insurance Portability and Accountability Act.

In the process of receiving health care at the University of Nevada, Las Vegas, a provider may initiate a follow up call and a letter may be sent to continue care. Also, patients may receive a phone calls to remind them of a scheduled appointment.

I understand that if I agree to participate in a research study, I will be provided with a specific authorization to participate. (*See Notice of Privacy Practices*). I have the option to choose not to participate or to withdraw from the study at any time.

I understand that I have the right to revoke in writing any such authorization, unless the University of Nevada, Las Vegas has already used or disclosed my information in reliance on the authorization.

I understand that I have the right to request restrictions on certain uses and disclosures of my health information to carry out treatment, payment, or healthcare operations and that the University of Nevada, Las Vegas is not required to agree to the restrictions requested.

Please note: I understand that if I request a restriction that may impede the ability of the University of Nevada, Las Vegas to provide proper care, or which restricts the release of information required by law to be released, that the University of Nevada, Las Vegas is unlikely to agree to the restriction and may cancel further services. Further, I understand that if I request a restriction that does not allow the University of Nevada, Las Vegas to release necessary information to insurance providers; it may affect my ability to obtain reimbursement for medical expenses.

I acknowledge receipt of a copy of the Notice of Privacy Practices, which contains a more complete description of uses and disclosure of patient health information.

I understand that the University of Nevada, Las Vegas reserves the right to change the Notice of Privacy Practices and a revised copy will be posted and available when requested.

Student-Athlete Signature: _____ **Date:** _____

Print Name: _____ **Date of Birth:** _____

If student-athlete is a minor:
Student-Athlete Representative Signature: _____ **Date:** _____

Description of Legal Guardianship: _____

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|------------------------------------|
| AIDS AND HEPATITIS - PART 5 |
|------------------------------------|

The Acquired Immunodeficiency Syndrome (AIDS) is caused by a virus or HIV (Human Immunodeficiency Virus). HIV has been isolated in blood, semen, vaginal secretions, saliva, tear, breast milk, cerebrospinal fluid, amniotic fluid, and urine. However, available evidence has implicated only blood, semen, vaginal secretion, and breast milk in the transmission of HIV. Another blood borne pathogen is the Hepatitis virus.

The risk of infection is increased by having multiple sex partners, homosexual activities and in sharing needles among intravenous drug users.

Sexual transmission of these diseases will be prevented by abstinence and reduced by limiting the number of sexual partners and by condom use. Needles (sometimes used to inject illicit drugs or ergogenic agents, such as anabolic steroids) should never be shared. Athletes should not share such personal items as water bottles, toothbrushes, razors, and nail clippers.

Although the precise risk of transmission during exposure of open wounds or mucous membranes to contaminated blood is not known, theoretically, there is a possibility of HIV and Hepatitis transmission by blood from one student-athlete to an open wound of another student-athlete.

Therefore, the intercollegiate athletics department, team physicians, and athletic trainers will employ universal precautions recommended by the Center for Disease Control in care of all student-athletes, since medical examination cannot reliably verify HIV and Hepatitis infected patients.

In addition, the Student Health Center on campus provides voluntary HIV testing free to all students. Testing for Hepatitis is also available at the Student Health Center. Information on testing dates may be obtained in the athletic training room or by calling the Student Health Center at 895-3370.

Student-Athlete Signature: _____

Date: _____

If student-athlete is a minor:

Student-Athlete Representative Signature: _____

Date: _____

Description of Legal Guardianship: _____