

UTAH STATE UNIVERSITY CLUB MEDICAL QUESTIONNAIRE

Name: _____ Birth date: _____

School Address: _____
City State Zip

School Phone: _____ Home Phone: _____

Home Address: _____
City State Zip

A#: _____ Insurance Plan: _____

Primary Care Physician: _____

Address: _____ Phone: _____

In case of Emergency, Notify: _____

Phone: _____ Relationship: _____

MEDICAL HISTORY

Have you ever had any of the following? If yes, give details and approximate date(s).

	No	Yes	Details and Date(s)
1. Medical Examination			
2. Are you allergic to any medication (aspirin, codeine, penicillin)			
3. Use of regular medication			
4. Do you require medication during activity?			
5. Any other allergies or skin conditions?			
6. Head injury/concussion			
7. Dizziness/Fainting/Convulsions			
8. Ear/Eye Disorders			
9. Use of Contact Lenses			
10. Dental Work (bridge, crown, plate, missing teeth)			
11. High/Low blood pressure			

	No	Yes	Details and Date(s)
12. Heart trouble/Rheumatic Fever			
13. Anemia/Bleeding Disorder			
14. Diabetes/Hepatitis			
15. Epilepsy			
16. Asthma (use of inhalants)			
17. Ulcers			
18. Kidney or bladder problems			
19. Emergency Alert Bracelet			
20. Previous surgery(ies)			
21. Pin, screw or plate as a result of surgery			
22. Joint Disorder (disloc/sep/fract)			
a) Neck-vertebrae (bones), discs			
b) Jaw			
c) Back-vertebrae (bones), discs			
d) Shoulder			
e) Elbow			
f) Wrist/Hand			
g) Hip			
h) Knee			
i) Ankle/Foot			
23. Other injuries/illnesses not listed above			

Signature of Athlete: _____ **Date:** _____