



Nebraska Wesleyan University Department of Athletics Medical History (Returning Athletes)

Name _____ Sex _____ Age _____
 Date of Birth _____ Student ID #: _____ Year in School _____
 Sport(s) _____
 Personal Physician _____ Physician's Phone _____
 Physician's Address _____

Explain "Yes" answer below: In the last 12 months...

1. Have you ever been hospitalized?..... Yes No
 Have you ever had surgery?..... Yes No
2. Are you presently taking any medications or pills?..... Yes No
3. Do you have any allergies (medicine, bees or other stinging insects)?..... Yes No
4. Have you ever passed out during or after exercise?..... Yes No
 Have you ever been dizzy during or after exercise?..... Yes No
 Have you ever had chest pain during or after exercise?..... Yes No
 Do you tire more quickly than your friends during exercise?..... Yes No
 Have you ever had high blood pressure?..... Yes No
 Have you ever been told that you have a heart murmur?..... Yes No
 Have you ever had racing of your heart or skipped heartbeats?..... Yes No
 Has anyone in your family died of heart problems or a sudden death before age 50?..... Yes No
5. Do you have any skin problems (itching, rashes, acne)?..... Yes No
6. Have you ever had a head injury?..... Yes No
 Have you ever been knocked out or unconscious?..... Yes No
 Have you ever had a seizure?..... Yes No
 Have you ever had a stinger, burn or pinched nerve?..... Yes No
7. Have you ever had heat or muscle cramps?..... Yes No
 Have you ever been dizzy or passed out in the heat?..... Yes No
8. Do you have trouble breathing or do you cough during or after activity?..... Yes No
9. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?..... Yes No
10. Have you had any problems with your eyes or vision?..... Yes No
 Do you wear glasses or contacts or protective eye wear?..... Yes No
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? If yes, please circle the body part..... Yes No

Head Shoulder Thigh Neck Elbow Knee Chest
 Forearm Shin/Calf Back Wrist Ankle Hip Hand Foot

12. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?..... Yes No
13. Have you had a medical problem or injury since your last evaluation?..... Yes No
14. When was your last tetanus shot?..... Date: _____
 When was your last measles immunization?..... Date: _____
15. When was your first menstrual period?..... Age: _____
 When was your last menstrual period?..... Date: _____
 What was the longest time between your periods last year?..... _____

Explain "Yes" answers:

I hereby state that, to the best of my knowledge, my answers to the above questions are correct and true.
 I fully realize that Nebraska Wesleyan University cannot be held liable for medical expenses derived from pre-existing injuries and/or conditions.
 I understand that the failure to disclose previous conditions *may* result in medical disqualification.

Athlete's Signature _____ Date _____