

**University of Sioux Falls working with  
Sanford Orthopedics & Sports Medicine  
MEDICAL HISTORY UPDATE**

The information provided on this form will help the Sports Medicine Staff/Team Physician(s) at the University of Sioux Falls and Sanford Orthopedics & Sports Medicine update your medical records for the coming year. Please answer all the questions to the best of your ability. Accuracy of this information provided is essential. Please be thorough when filling out this form, this will expedite your athletic medical clearance by our medical team for this athletic season/year. Please use ink and write legibly on form.

<u>PERSONAL INFORMATION</u>	
TODAY'S DATE: _____	
(Please check) SO _____ JR _____ SR _____ 5 <sup>th</sup> _____	
Full Name _____	Date of Birth _____
Social Security # _____	Age: _____ Sport(s) _____
Home Address _____	School Address _____
City: _____	City: _____
State: _____	State: _____
Zip: _____	Zip: _____
Home phone: _____	Local Phone: _____
Cell Phone: _____	Email: _____

Emergency Contact Information

-2-

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Home Address \_\_\_\_\_ Work Address \_\_\_\_\_

City: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Relationship to Athlete: \_\_\_\_\_

**RELEASE OF MEDICAL RECORDS:**

I, \_\_\_\_\_, hereby request and authorize any medical facility and/or organization listed, to release all information (including but not limited to history and physical, laboratory reports, x-ray reports, operative reports, discharge summaries, ER reports, and cardiovascular reports) included in my complete medical record to:

**HEAD ATHLETIC TRAINER**  
University of Sioux Falls  
1210 West 18<sup>th</sup> Street, Suite LL01  
Sioux Falls, SD 57104

I release the above named person from all legal responsibility or liability that may arise from the act I have authorized. This authorization shall be in effect for one year from this date. I also agree to sign future releases of medical records as may be needed in order to process any claims that may be filed.

Athlete Signature \_\_\_\_\_ Date \_\_\_\_\_

Medical Staff  
Signature \_\_\_\_\_ Date \_\_\_\_\_

Medical History Update Questionnaire

-3-

When did you complete your physical with Sanford Hospital? Month \_\_\_\_\_ Year \_\_\_\_\_

Please Circle the Appropriate Answer:

- |     |    |   |
|-----|----|---|
| YES | NO | 1. Have you been hospitalized within the last year? <b>If yes, what was the date, hospital location and reason for hospitalization?</b><br>_____<br>_____   |
| YES | NO | 2. Have you experienced <u>ANY</u> injury to your bone, joints or muscles within the last year? <b>If yes, please indicate site and nature of your injury:</b><br>_____<br>_____  |
| YES | NO | 3. Have you experienced any illness requiring the services of a physician within the last year? <b>If yes please explain:</b> _____<br>_____  |
| YES | NO | 4. Have you recently developed any known allergies or medical conditions? <b>If yes, please identify:</b><br><b>Allergy and/or Medical Condition</b> _____<br>_____   |
| YES | NO | 5. Are you currently taking ANY medication, vitamins, or supplements on a daily/regular basis? (ex: birth control/inhaler/protein supplement/multi-vitamin) <b>If so, please identify name and/or brand of medication, vitamin, or supplement:</b> _____<br>_____ |
| YES | NO | 6. Have you received any recent immunizations? <b>If so, please identify:</b><br>_____<br>_____   |
| YES | NO | 7. Have you recently experienced any significant change in weight? <b>If so, please explain:</b> _____<br>_____   |
| YES | NO | 8. Are you currently ill? <b>If yes, what are your symptoms?</b> _____<br>_____   |
| YES | NO | 9. Do you currently have a bone, joint, or muscle injury that is <b>not</b> completely healed? <b>If yes, please indicate nature and site:</b> _____<br>_____<br>_____  |

**Medical History Update Questionnaire continued**

-4-

**YES      NO**      **10.** Have you ever been seen by a physician or hospitalized for a concussion(s)? **If yes, when was the concussion(s) (month and year)?**

\_\_\_\_\_

\_\_\_\_\_

**YES      NO**      **11.** Is there any reason(s) not listed that would prohibit you from **full participation** in your listed sport(s)? **If yes, please explain:**

\_\_\_\_\_

\_\_\_\_\_

**MALES ONLY:**

**YES      NO**      Have you had any significant testicular problem in the last year? **If yes, please explain:**

\_\_\_\_\_

\_\_\_\_\_

.....

**FEMALES ONLY:**

**YES      NO**      Have you had any problems with your menstrual period within the last year?  
**YES      NO**      When was your most recent menstrual period? Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
**YES      NO**      Have you stopped menstruating in the last year?  
**YES      NO**      Have you had a gynecology exam (pap smear) within the last year?

**If you answered yes to any of the above questions, please explain:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

.....

**The information I have provided in this medical history update form is true and correct to the best of my knowledge.**

ATHLETE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Reviewed By: \_\_\_\_\_ DATE \_\_\_\_\_

(Certified Athletic Trainer)