**BETHEL UNIVERSITY**
**Athletics Department**

**Save a copy for your records!**

**Upload completed forms to the Bethel Moodle Course for your sport by August 1** (multi-sport athletes upload to the sport that competes earliest)

Questions: Justin Byers, Director of Athletic Training Services, jbyers@bethel.edu

# HEALTH HISTORY RECORD
# TO BE COMPLETED BY THE ATHLETE

## I. STUDENT'S REPORT OF MEDICAL HISTORY… (PLEASE PRINT)

==========

| Last Name | First Name | Middle | Gender | Date of Birth |
|---|---|---|---|---|
| Home Address (Number and Street) | City or Town | State | Country | Zip |
| Sport | Bethel ID (if known) | Cell phone (to contact you with questions or clarifications) | | |

**PLEASE CHECK YES and explain if you have had any of the following diseases or conditions or CHECK NO if not**

| **GENERAL** | **Yes** | **No** |
|---|---|---|
| Has a doctor ever denied or restricted your participation in sports for any reason or told you to give up sports? | ☐ | ☐ |
| Do you have ongoing medical conditions (i.e. diabetes, asthma)? | ☐ | ☐ |
| Have you ever spent the night in a hospital? | ☐ | ☐ |
| Have you ever had surgery? | ☐ | ☐ |
| Have you ever had a hernia? | ☐ | ☐ |
| Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | ☐ | ☐ |
| Have you ever been told you have protein/sugar in your urine? | ☐ | ☐ |
| When exercising in the heat, do you have severe muscle cramps or become ill? | ☐ | ☐ |
| Do you have any concerns that you would like to discuss with a doctor? And what are they? | ☐ | ☐ |
| -Explanation of Above: | | |

| **ALLERGIES** | **Yes** | **No** |
|---|---|---|
| Do you have allergies to any medications? | ☐ | ☐ |
| If yes, please list | | |
| Other allergies: | ☐ | ☐ |
| If yes, please list | | |
| -Explanation of Above: | | |

| **CARDIOVASCULAR** | **Yes** | **No** |
|---|---|---|
| Have you ever passed out or nearly passed out DURING exercise? | ☐ | ☐ |
| Have you ever passed out or nearly passed out AFTER exercise? | ☐ | ☐ |
| Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | ☐ | ☐ |
| Does your heart race or skip beats during exercise? | ☐ | ☐ |
| Has a doctor ever told you that you have? (circle all that apply) High Blood Pressure High Cholesterol A Heart Infection or Murmur Rheumatic Fever | | |
| Has a doctor ever ordered a test for your heart? (i.e. ECG, echocardiogram, stress test) | **Yes** | **No** |
| Has anyone in your family died suddenly and unexpectedly for no apparent reason? | ☐ | ☐ |
| Does anyone in your family have a heart problem? | ☐ | ☐ |
| Has any family member or relative died of heart problems or of sudden death before age 35? Age 50? | ☐ | ☐ |
| Does anyone in your family have Marfan syndrome? | ☐ | ☐ |
| -Explanation of Above: | | |

| **ORTHO** | **Yes** | **No** |
|---|---|---|
| Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or a game? | ☐ | ☐ |
| Have you had any broken or fractured bones, or dislocated joints? | ☐ | ☐ |
| Have you had a bone/joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches? | ☐ | ☐ |
| If yes, circle below:<br>Head Neck Shoulder Chest Upper Arm Elbow Forearm Hand/Fingers Upper Back Lower Back Hip Thigh Knee Calf/Shin Ankle Foot/Toes | | |
| Have you ever had a stress fracture or stress reaction? | ☐ | ☐ |
| Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | ☐ | ☐ |
| Do you regularly use a brace or assistive device? | ☐ | ☐ |
| -Explanation of Above: | | |

| **RESPIRATORY** | **Yes** | **No** |
|---|---|---|
| Has a doctor ever told you that you have asthma or allergies? | ☐ | ☐ |
| Do you cough, wheeze, have chest tightness, or have difficulty breathing during or after exercise? | ☐ | ☐ |

| | | |
|---|---|---|
| Is there anyone in your family who has asthma? | ☐ | ☐ |
| Have you ever used an inhaler or taken asthma medicine? | ☐ | ☐ |
| Do you develop a rash or hives when you exercise? | ☐ | ☐ |
| Do you get tired more quickly than your friends do during exercise? | ☐ | ☐ |
| -Explanation of Above: | | |
| **INFECTIOUS** | **Yes** | **No** |
| Have you recently had a Tuberculosis Skin Test? If yes; results were: Negative Positive | ☐ | ☐ |
| Have you had infectious mononucleosis (mono) within the last month? | ☐ | ☐ |
| Have you had chicken pox? | ☐ | ☐ |
| Have you had measles? | ☐ | ☐ |
| Have you had mumps? | ☐ | ☐ |
| -Explanation of Above: | | |
| **SKIN** | **Yes** | **No** |
| Do you have any rashes, pressure sores, or other skin problems? | ☐ | ☐ |
| Have you had a herpes skin infection? | ☐ | ☐ |
| -Explanation of Above: | | |
| **NEUROLOGIC** | **Yes** | **No** |
| Have you ever had a head injury; concussion; been knocked out or had your "bell rung"? | ☐ | ☐ |
| Have you been hit in the head and been confused or lost your memory? | ☐ | ☐ |
| Have you ever had a seizure? | ☐ | ☐ |
| Do you have headaches with exercise? | ☐ | ☐ |
| Have you ever had a "stinger or burner" | ☐ | ☐ |
| Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | ☐ | ☐ |
| Have you ever been unable to move your arms or legs after being hit or falling? | ☐ | ☐ |
| -Explanation of Above: | | |
| **BLOOD** | **Yes** | **No** |
| Have you ever been told you are anemic? | ☐ | ☐ |
| Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | ☐ | ☐ |
| Have you been tested for sickle cell trait? | ☐ | ☐ |
| Any other blood disorder? | ☐ | ☐ |
| -Explanation of Above: | | |
| **VISION** | | |
| Have you had any problems with your eyes or vision? | ☐ | ☐ |
| Do you wear glasses or contact lenses? | ☐ | ☐ |
| Do you wear protective eyewear, such as goggles or a face shield? | ☐ | ☐ |
| -Explanation of Above: | | |
| **NUTRITION** | **Yes** | **No** |
| Are you taking any supplements? | ☐ | ☐ |
| Are you happy with your weight? | ☐ | ☐ |
| Are you trying to gain or lose weight? | ☐ | ☐ |
| What has been your highest & lowest weight in the past 12 months? _____ | | |
| Has anyone recommended you change your weight or eating habits? | ☐ | ☐ |
| Do you limit or carefully control what you eat? | ☐ | ☐ |
| Have you ever been diagnosed with an eating disorder? | ☐ | ☐ |
| -Explanation of Above: | | |
| **FEMALES ONLY** | **Yes** | **No** |
| Have you ever had a menstrual period? | ☐ | ☐ |
| How old were you when you had your first menstrual period? _____ | | |
| How many menstrual periods have you had in the last year? _____ | | |
| -Explanation of Above: | | |
| **MALES ONLY** | **Yes** | **No** |
| Have you ever had an injury to a testicle or other reproductive organs? | ☐ | ☐ |
| Do you or have you had undescended testicles? | ☐ | ☐ |
| -Explanation of Above: | | |
| **ENT** | **Yes** | **No** |
| Have you had multiple ear infections? | ☐ | ☐ |
| Do you have loss of hearing in one or both ears? | ☐ | ☐ |
| -Explanation of Above: | | |
| **ABDOMINAL** | **Yes** | **No** |
| Have you ever had an ulcer? | ☐ | ☐ |
| Do you have a history of gastrointestinal (GI) problems? | ☐ | ☐ |
| Do you experience abdominal pain multiple times per month? | ☐ | ☐ |
| Have you had your appendix removed? | ☐ | ☐ |
| -Explanation of Above: | | |

| UROLOGY | Yes | No |
|---|---|---|
| Have you had multiple urinary tract /bladder infections? | □ | □ |
| Have you ever had a kidney infection? | □ | □ |
| Have you ever had kidney or gall stones? | □ | □ |
| -Explanation of Above: | | |

## PERSONAL HISTORY

PLEASE ELABORATE ON ANY POSITIVE ANSWERS WITH ADDITIONAL COMMENTS IN THE SPACE PROVIDED BELOW.
(ALL ANSWERS ARE CONFIDENTIAL)

A. List any illness, injury, surgery, or hospitalization (gives dates and explain).

B. List any medications taken routinely. Reason and Type:

C. List any food allergies or dietary restrictions (i.e. vegetarian, lactose intolerant, gluten free, etc.)

D. Have you ever been diagnosed and/or treated for ADD/ADHD □Yes □ No
Do you currently take medication to help manage your ADD/ADHD? If yes, what do you take? □Yes □ No

E. Have you ever been diagnosed or treated for a mental health condition □ Yes □ No
If yes, for which of the following conditions have you been diagnosed or treated? (please check all that apply)

□ Depression
□ Anxiety
□ Substance abuse or dependency
□ Bipolar Disorder
□ Anorexia or bulimia
□ Other (please list: _____)

F. Do you currently take medication to help manage a mental health condition? □ Yes □ No
If yes, what do you take?

G. Have you ever been hospitalized for a mental health condition? □ Yes □ No

H. Family History: ages of living or if deceased; plus Health Issues

Father Mother Siblings Others

## Please read and sign below before participation in any athletic activity.

The staff of Bethel University Health Services and Sports Medicine Staff works hard to maintain strict confidentiality. However, in order for you to perform safely as an athlete, the Health Services and Sports Medicine Staff may release information back and forth regarding your medical condition. This includes information concerning current medications, allergies (ex. Bee Stings), need for corrective lenses, and health of any medical condition or injury that may need to be monitored during your participation in sports.

It is because of our strong concern for confidentiality that we want you to be aware of this procedure prior to your participation. Our aim is to help you safely participate in the Bethel University athletics program.

Statement:

I authorize Bethel University Health Services and the Sports Medicine Staff to share information of my current health history record, physical examination, immunization records as well as information regarding future medical conditions that may develop while I participate in intercollegiate sports at Bethel University.

Student's Signature Birthdate Date

***If you are under 18 please have your parent/guardian sign below.*** *Students under 18 years of age must have parental permission to receive medical treatment or emergency care through our Health Services and Athletic Training Departments. I give permission for my son/daughter to receive medical treatment or emergency care through the Health Services and Athletic Training Departments.*

*Parent/Guardian Signature*

# Bethel University
# MEDICAL EXAMINATION
# TO BE COMPLETED BY THE EXAMINING HEALTH CARE PROVIDER (i.e. MD, DO, NP, PA)

****Please keep a copy for your records and upload a copy of entire form to the Bethel Moodle Course for your sport****

Questions: Justin Byers, Director of Athletic Training Services, e-mail: jbyers@bethel.edu

**Student's Name** **Date of Birth** **Age** **Gender** **DATE OF EXAM**

***MEDICAL EXAMINATION – MUST BE COMPLETED WITHIN 6 MONTHS OF COMING TO BETHEL UNIVERSITY***

**Height: _____ Weight: _____ BMI (optional) _____ Arm Span _____(screen for Marfan Syndrome)**

**Pulse: _____ BP: _____/_____ Respirations_____ Temperature_____**

**Vision: R - 20/_____ L 20/ _____ Corrected: Yes/No Contacts Yes/No Pupils: Equal _____ Unequal _____**

| EXAM | NORMAL | ABNORMAL (explain) |
|---|---|---|
| **Appearance** | Y/N | |
| **HEENT** | Y/N | |
| Eyes | Y/N | |
| Fundoscopic | Y/N | |
| Pupils | Equal/Unequal | |
| Ears/Nose | Y/N | |
| Hearing | Y/N | |
| Throat | Y/N | |
| Dental | Y/N | |
| Lymph Nodes | Y/N | |
| Thyroid | Y/N | |
| **Lungs** | Y/N | |
| **Cardiac (including precordial supine & standing and femoral artery pulses)** | Y/N | |
| **Abdomen** | Y/N | |
| **Genitourinary (male)** | Y/N | |
| Hernia | Y/N | |
| **Skin** | Y/N | |
| **Musculoskeletal** | | |
| Neck | Y/N | |
| Back | Y/N | |
| Shoulder/Arm | Y/N | |
| Elbow/Forearm | Y/N | |
| Wrist/Hand/Fingers | Y/N | |
| Hip/Thigh | Y/N | |
| Knee | Y/N | |
| Leg/Ankle | Y/N | |
| Foot/Toes | Y/N | |
| Duck Walk | Y/N | |
| Neurological | Y/N | |
| Psychological | Y/N | |
| | | |

Is patient under treatment of any kind at this time? □ Yes **:** □ No
Explain:

Physical/Mental Disabilities or impairment? □ Yes **:** □ No
Explain:

# BETHEL UNIVERSITY
# INTERCOLLEGIATE SPORT MEDICAL CLEARANCE FORM

****Please keep a copy for your records and upload a copy of entire form to the Bethel Moodle Course for your sport****
Questions: Justin Byers, Director of Athletic Training Services, e-mail: jbyers@bethel.edu

**Student Name: _____ Date of Birth: _____ Gender: _____**

**Anticipated sport(s) participation (see list below):_____**

**Date of Examination: _____(MUST BE WITHIN 6 MONTHS PRIOR TO PARTICIPATION)**

I certify that the above student has been medically evaluated and is deemed to be physically fit to:
**(Check one box)**

_____Participate in **ALL** Bethel University Varsity Sports

_____**Not cleared** for these specific sport activities (list all that apply) EXPLAIN: _____
_____

_____**Not cleared** for **ANY** sports activities. EXPLAIN:
**_____**

_____

_____Requires further evaluation before a final recommendation can be made. EXPLAIN: _____

_____

**I have examined the above named student, reviewed their health history form and have completed the sports qualifying physical examination as requested.**

Health Care Provider Signature: _____ Printed Name: _____

Clinic Address: _____

Office Phone: _____Office Email: _____Office FAX: _____

**DATE_____ (MUST BE WITHIN 6 MONTHS PRIOR TO PARTICIPATION)**

## BETHEL UNIVERSITY SPORT ACTIVITIES

**Intercollegiate Sports**

| | | |
|---|---|---|
| **Baseball** | **Golf** | **Tennis** |
| **Basketball** | **Soccer** | **Track & Field** |
| **Cross Country** | **Softball** | **Volleyball** |
| **Football** | **Hockey** | |