

WVU Tech Athletics Medical History

Name _____	Date of Birth _____	Age _____	Sport _____
Home Address _____			
(Street)		(City)	
(State)		(Zip)	
Emergency Contact Name: _____		Relationship: _____	
Telephone # (H)(____)	(C)(____)	(W)(____)	
Primary Physician Name _____		Telephone (____)	

Personal Health History: To Be Completed By Student

Has Any Blood Relative Ever Had...

	YES	NO		YES	NO
Cancer _____			Suicide _____		
Diabetes _____			Alcoholism/Drug Abuse _____		
Heart Trouble _____			Die Suddenly before age 50 _____		
High Blood Pressure _____			Bleeding Disorder _____		
Stroke _____			Blood Disease _____		
Epilepsy/Seizures _____			Other _____		
Mental Illness/Depression _____					

Are You Allergic to...

	YES	NO		YES	NO
Aspirin _____			Any foods _____		
Codeine _____			Tetanus antitoxin _____		
Sulfa drugs _____			Novacaine _____		
Penicillian _____			Bee Sting _____		
Dust/Mold/Pollen/Grass _____			Any other drug (_____) _____		

Have You Ever Had...

	YES	NO		YES	NO
See a Dr. regularly _____			Anemia _____		
For what illness _____			Blood in urine _____		
Missing organs _____			High blood pressure _____		
Diabetes _____			Chest pain with exercise _____		
Cancer _____			Passed out or fainted with exercise _____		
Heat Exhaustion _____			Heart problems _____		
How many times _____			Fast heartbeat _____		
Last time _____			Skipped heartbeat _____		
Any daily medication _____			Heart murmur _____		
Frequent Headaches _____			Nervous stomach or irritable bowel _____		
Dizziness while exercising _____			Ulcers _____		
Fainting Spells _____			Frequent Diarrhea _____		
Concussions _____			Blood in bowel movement _____		
How many _____ Last one _____			Hernia _____		
Epilepsy/Seizures _____			Hepatitis _____		
Ear disease or Hearing problem _____			Kidney or bladder infections _____		
Frequent Nose bleeds _____			Kidney Stones _____		
Frequent Sore Throat _____			Testicular Torsion _____		
Mononucleosis _____			Have you ever been to an eye Dr _____		
Thyroid disease or problem _____			Do you wear contact lenses to participate _____		
Persistent cough _____			Have you ever had an eye injury _____		
Pneumonia _____			Have you ever had a dental injury _____		
Depression _____					

Have you ever had...

	YES	NO	
Broken bone _____			<i>Females only</i>
Dislocated joint _____			When was your last menstrual period? _____
Orthopedic surgery _____			How long does your menstrual period usually last? _____
			How many periods have you had in the past 12 months? _____
			Do you take birth control pills? If so, which one (s)? _____

If you answered "YES" to any of the above questions and/or have any further information, which is knowledgeable to you and not required on this form, please explain in detail below (use additional sheet(s) if necessary)-

I, the undersigned, hereby acknowledge, affirm, and represent that all above statements are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

Student-Athlete Signature _____ Date: _____