UNIVERSITY HEALTH SERVICES
Tang Center

Intercollegiate Athletics

University of California, Berkeley

PERSONAL INFORMATION

Last Name	*First Name*	*MI*	*Sex*	*Social Security Number*	*Date of Birth*

UHS Medical Record #	*Student ID Number (Reg #)*	*Sport / Event / Position*	❒ Returning UCB athlete ❒ New UCB athlete
Campus Street Address *City/Zip*		*Pager/Cell Phone Number* ( )	Campus Phone Number
Parents'/Guardians' Names	*Relationship* ❒ Father ❒ Mother ❒ Other ❒ Father ❒ Mother ❒ Other	*Work/Cell Phone Numbers* ( ) ❑ wk ❒ c ( ) ❒ wk ❒ c	*Home Phone Numbers* ( ) ( )
Parents'/Guardians' *Street Address*		*City*	*State/Zip*

PRIMARY HEALTH INSURANCE INFORMATION

Please have parents help you complete this section. ❒ Student Health Insurance Plan (SHIP). ❒ I have additional insurance through family.	*Pre-authorization Phone #* ( )	*Primary Care Physician's Name*	*Physician's Phone #* ( )
Additional Health Insurance Company (Parent's/Guardian's) ❒ HMO ❒ PPO		*Policy Number*	*Group Number*
Insurance Company's Address		*City* *State/Zip*	*Insurance Company's Phone #* ( )
Name of Insured Parent or Guardian	*Relationship* ☐Father ☐Mother ☐Other	*Insured's Social Security #*	*Insured's Date of Birth*

MEDICAL HISTORY (Orthopedic)

Yes	No	*Check whether you have had any of the following injuries.* *If* YES, *provide approximate date(s) and details.*
❒	❒	Concussion or head injury
❒	❒	Broken nose
❒	❒	Neck injury involving nerves, bones, or spinal cord, including stingers
❒	❒	Shoulder dislocation, separation or other shoulder injury
❒	❒	Elbow injury
❒	❒	Wrist injury
❒	❒	Hand or finger injury
❒	❒	Back injury, or low back pain that required medical treatment
❒	❒	Hip injury
❒	❒	Knee injury
❒	❒	Ankle injury
❒	❒	Foot injury
❒	❒	Other fractured bone, or stress fracture
❒	❒	Other significant musculoskeletal injury (e.g. shin splints, pelvic, groin, hamstring injuries)

UHS #

NAME

DOB

Athlete's Health History

MEDICAL HISTORY (continued)

List the approximate dates and details of any previous surgeries not listed above.

List the approximate dates and details of any hospitalizations for reasons other than surgery not listed above.

Yes	No	*Check whether **you or a family member** has had any of the following conditions. If YES, provide approximate date(s) and details; if family member, specify relation to you.*	Yes	No	
❒	❒	Heart murmur	❒	❒	Irregular heart beat or extra beats
❒	❒	Chest pains or heart palpitations with or without exercise	❒	❒	Excessive or unexplained shortness of breath or excessive fatigue with exercise (e.g. asthma)
❒	❒	Fainting or near-fainting, passed out	❒	❒	Sudden death without warning before age 50
❒	❒	High blood pressure	❒	❒	Other history of heart problems

Yes	No	*Check whether you have ever had any of the following conditions. If YES, provide approximate date(s) and details.*	Yes	No	
❒	❒	Anemia (including sickle cell trait)	❒	❒	Kidney or bladder problem
❒	❒	Asthma, allergy, hay fever	❒	❒	Liver disease (hepatitis)
❒	❒	Blood clots/ Bleeding disorders	❒	❒	Migraine headaches
❒	❒	Breast lump or discharge	❒	❒	Mononucleosis
❒	❒	Chemical dependency	❒	❒	Skin problems
❒	❒	Depression or recurring anxiety	❒	❒	Testicular or other genital problems
❒	❒	Diabetes	❒	❒	Thyroid disease
❒	❒	Eating disorder	❒	❒	Ulcers, stomach problem
❒	❒	Epilepsy or seizures	❒	❒	Ulcerative colitis, Crohn’s disease
❒	❒	Frequent diarrhea/constipation (specify/circle)	❒	❒	Unusual bleeding or bruising
❒	❒	Heat illness or cramps	❒	❒	Weight loss greater than 10 lbs
❒	❒	Hernia	❒	❒	Other

Last Name	*First Name*	*MI*

Athlete's Health History

Medications	Dosage and Frequency	Reason for taking
List all medications you are presently taking. *Include prescriptions, over-the-counter medications, performance enhancers/supplements, vitamins, birth control pills.*		

Yes	No	*Check whether you have had any of the following conditions.* *If* YES, *provide approximate date(s) and details.*
❒	❒	Allergy or severe reaction to any medication *(specify type of reaction)*
❒	❒	Any other allergy, or severe reaction to insect, bees, wasps or food *(specify type of reaction)*
❒	❒	Do you wear glasses or contacts? *Circle one.* glasses contacts both Approximate dates of last eye exam ___________
❒	❒	A dental plate or a broken, chipped or loose tooth *(specify)*
❒	❒	Are you missing any of the following organs X eye, kidney, testicle? *(specify)*
❒	❒	I use/used tobacco products. *Circle all that apply.* smokeless tobacco cigars pipe cigarettes packs/day ____ years smoked _____
❒	❒	In the past year did you drink any alcohol? *Circle average/typical use* **1 or fewer** **2-3** **4-5** **more than 5** drinks/week
❒	❒	*Check, which is applicable* I am ❒ **over-weight** or ❒ **under-weight** ❒ **ideal weight – specify** ___________

Specify any special diet you follow.

For women only	
Date of your last menstrual period	*Number of periods you have had in the last 6 months*
Usual length of time between your periods	*Date of last pelvic exam and Pap smear*
Date(s) and details of abnormal Pap smear(s) or other findings	*Longest time (in months) you have gone without a menstrual cycle* ______ Months

IMMUNIZATION HISTORY

Yes	No	*Check whether you have been immunized for any of the following. If* YES, *provide approximate date(s) and details. Also indicate if you have ever been diagnosed with any of the following.*	Yes	No	
❒	❒	German measles (rubella)	❒	❒	Pertussis (Adacel)
❒	❒	Hepatitis B (**attach required form from web site**)	❒	❒	Polio
❒	❒	HPV (Gardisil)	❒	❒	Tetanus *(date of last booster ____________)* tdap _______
❒	❒	Measles *(year of 2nd shot ______________________)*	❒	❒	Tuberculosis skin test *(year _______)* 1 negative 1 positive
❒	❒	Meningoccocal (Menomune or Menactra: specify____________)	❒	❒	Varicella/chicken pox
❒	❒	Mumps	❒	❒	Other (pneumovax, influenza)

I have answered the above questions truthfully to the best of my knowledge.

Athlete's Signature	***Date***
Parent's or Guardian's Signature	***Date***

Last Name	*First Name*	*MI*

Athlete's Health History