

EASTERN OREGON UNIVERSITY

Sports Pre-participation History

Name: _____ Gender: _____ Age: _____ Date of Birth: ___/___/___ Class: F / S / J / SR
 Date: _____ Sport(s) you are participating in: _____

Circle N for no, Y for yes, and EXPLAIN "Yes" answers in space provided (additional space below):

- N / Y 1. When was your last tetanus shot? (Month/Year) _____ last measles immunization? _____
- N / Y 2. Has a health care provider ever denied or restricted your athletic participation? when/why _____
Were you released to return to play, and if so by whom/when/why? _____
- N / Y 3. Do you have any allergies (meds, insects, other)? _____
- N / Y 4. Have you ever been hospitalized? why/when _____
- N / Y 5. Have you ever had surgery? why/when _____
- N / Y 6. Are you presently taking any prescription medications? (Including Birth Control Pills)
List: _____
- N / Y 7. Are you presently taking over the counter pills, vitamins or any performance enhancing substances?
List: _____
- N / Y 8. Have you ever passed out, been dizzy, or had a seizure during or after exercise? (Circle symptom)
Describe when & why _____
- N / Y 9. Have you ever had high blood pressure? Highest readings? _____ when _____
- N / Y 10. Have you ever been told that you have a heart murmur? when _____ what kind _____
- N / Y 11. Have you ever had severe racing of your heart, skipped heartbeats, or chest pain? when _____ describe _____
- N / Y 12. Has anyone in your family died of heart problems, or a sudden death before, or close to, the age 50?
Who _____ At what age _____ What kind of problem _____
- N / Y 13. Do you have any skin problems (itching, rashes, acne)? describe _____
- N / Y 14. Have you ever had a head injury? when _____ describe _____
- N / Y 15. Have you ever been knocked out or unconscious? when _____ describe _____
- N / Y 16. Have you ever had a stinger, burner, or pinched nerve? when _____ describe _____
- N / Y 17. Do you experience recurring muscle cramps? when _____ describe _____
- N / Y 18. Have you ever been dizzy or passed out in the heat? when _____ describe _____
- N / Y 19. Do you have asthma, trouble breathing, or cough during or/after activity? when _____ describe _____
- N / Y 20. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any of these body parts, or other joints?
 Head Neck Chest Back
 Shoulder Upper arms Elbows Forearms Wrists Hands
 Hips Thighs Knee Shin/Calf Ankle Foot

Indicate injured area, date of injury(s), how it was treated, and any ongoing problems _____

- N / Y 21. Is there loss or seriously impaired function of any of your paired organs? _____
- N / Y 22. Have you ever had any serious concern about your weight/body image, or been diagnosed with an eating disorder?
when _____ describe _____

(Women Only)

- N / Y 23. Are you currently pregnant?
When was your first menstrual period? (age) _____
What was the 1st day of your last period? _____
What was the longest time between your periods in the last 5 years? _____
When/why/how it was corrected _____

Additional space for explanations of above "Yes" answers:

Check any of the following illnesses that **you** have had:

Major Medical Illness:

- | | | | |
|-----------------------------------------|------------------------------------------|----------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis/Joint deformity |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Ulcers/GI | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia (low iron or RBC's) |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Heart Problem | <input type="checkbox"/> |
| <input type="checkbox"/> Kidney/Bladder | <input type="checkbox"/> Severe Anxiety | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hearing loss |

Any other major illness, describe treatment of above: _____

Check any of the following **Family History** of problems:

- | | | | | | |
|-------------------------------------------|----------------------------------------------|------------------------------------------|-------------------------------------|------------------------------------------|---------------------------------|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Arthritis/joints | <input type="checkbox"/> Kidney/Bladder | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Eating Disorder | |

Describe: _____

Your Health Habits:

- | | |
|-----------------------------------------------------------------------------------------------------------------------------|-----------------------------|
| <input type="checkbox"/> Alcohol , how many <i>drinks/day</i> when you drink _____/day, | Total drinks _____/WEEK |
| <input type="checkbox"/> Smoke Cigarettes , how many cigarettes in a day _____? | Packs(20 cig/pk) _____/WEEK |
| <input type="checkbox"/> Chew Tobacco , how many times in a day _____? | Cans _____/WEEK |
| <input type="checkbox"/> Caffeine products , how many cups of <i>coffee, tea, or cans of caffeinated soda</i> a day? | _____ /DAY |

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of Athlete: _____ Date: _____

Reviewed by (NP) _____ Date: _____



EASTERN OREGON UNIVERSITY

**Student Health & Counseling Center
One University Blvd.
La Grande, Oregon 97850
(541) 962-3524 Fax (541) 962-3825**

MEDICAL RECORDS REQUEST

Patient Name:

Patient Phone #:

Date of Birth:

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize: **EOU STUDENT HEALTH CENTER
EASTERN OREGON UNIVERSITY
ONE UNIVERSITY BLVD.
LA GRANDE, OREGON 97850
PHONE: (541) 962-3524; FAX: (541) 962-3825**

To use and disclose a copy of the specific health information described below regarding:

(Name of Individual)

Consisting of: **Athletic Pre-Participation Clearance and any related Treatment or Recommendations.**

TO: EOU Athletic Department and EOU Athletic Trainers

For the purpose of: **AT THE REQUEST OF INDIVIDUAL FOR CONTINUITY OF CARE.**

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my **initials** in the applicable space next to the type of information.

- _____ HIV / AIDS Information
- _____ Mental Health Information
- _____ Genetic Testing Information
- _____ Drug / Alcohol Diagnosis, Treatment or Referral Information

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign will mean you will not receive health services is if the health services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any uses or disclosures already made with your permission cannot be undone.

To revoke this authorization, please send a written statement to Eastern Oregon University Student Health at the address above and state that you are revoking this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV / AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

I have read this authorization and I understand it.

Unless revoked, this authorization expires _____ (insert applicable date or event).

By: _____ Date: _____
(Signature of individual or personal representative)

Description of personal representative's authority: _____