Returning Member Medical Update Form

Date: _____/_____/_____

Student's name: _____
(last) (first) (middle) (nickname)

Date of birth: _____/_____/_____ Age: _____ Race: _____ Sex at birth: M / F
(month) (day) (year)

Social Security No: _____/_____/_____ Student ID: _____

Local address (apartment, dorm, etc.): _____
(street)

_____ _____ _____
(state) (city) (zipcode)

Cell phone: _____ - _____ - _____ Home phone: _____ - _____ - _____

E-mail address: _____

Section in band: ☐ Brass
☐ Color guard
☐ Drum major
☐ Maroonettes
☐ Twirlers
☐ Percussion
☐ Woodwinds

Year in school: ☐ Freshman
☐ Sophomore
☐ Junior
☐ Senior
☐ Other: _____

Emergency Contact 1:
Name: _____ Relationship to student: _____

Cell phone: _____ - _____ - _____ Home phone: _____ - _____ - _____

Emergency Contact 2:
Name: _____ Relationship to student: _____

Cell phone: _____ - _____ - _____ Home phone: _____ - _____ - _____

Name of Primary Care Physician: _____

Address _____
(street) (state) (city) (zipcode)

Business phone: _____ - _____ - _____

Name: _____ Date: _____

Personal Medical History: Do you have any of the following medical conditions?

Yes	No	Alcoholism/Drug Abuse
Yes	No	AIDS or HIV
Yes	No	Anemia
Yes	No	Asthma or Exercise-Induced Asthma (EIA)
Yes	No	Cancer
Yes	No	Diabetes
Yes	No	Epilepsy/Seizure Disorder
Yes	No	Frequent Headaches or Migraines
Yes	No	Heart Condition (please provide diagnosis below)
Yes	No	Hypertension
Yes	No	Hypoglycemia
Yes	No	Hypotension
Yes	No	Mental Illness (please provide diagnosis below)
Yes	No	Sickle Cell Trait/Disease
Yes	No	Thyroid Disease

Please list **ALL** medical conditions (including any checked above): _____

_____

_____

Do you have any emergency medications (i.e. glucagon, Epi-Pen, inhaler)? Yes No

If yes, please list: _____

If yes, do you keep your emergency medication with you? Yes No

Please list any FOOD allergies: _____

_____

_____

Please list any ENVIRONMENTAL allergies: _____

_____

_____

Please list any MEDICATION allergies: _____

_____

_____

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Name: _____ Date: _____

Please list any medications you are currently taking: _____

_____

_____

Please list any supplements, vitamins, or minerals you are currently taking: _____

_____

_____

Have you had a concussion in the last 12 months? Yes No

If yes, were you cleared by a medical professional to return to activity? Yes No

Have you been hospitalized in the last 12 months? Yes No

If yes, for what? _____

Have you had surgery in the last 12 months? Yes No

If yes, for what? _____

Have you broken any bones in the last 12 months? Yes No

If yes, what did you break? _____

In the last 12 months, have you had any of the following tests performed for a heart condition?

☐ Electrocardiogram (EKG)

☐ Echocardiogram

☐ Treadmill Stress Test

If yes, for what condition were you tested? _____

Do you use any of the following?

☐ Chewing Tobacco

☐ Snuff

☐ Smokeless Tobacco

☐ Cigarettes

☐ Cigars

☐ Pipe

☐ Vape

☐ Other: _____

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Name: _____ Date: _____

In the last 12 months, have you been diagnosed with or treated for any of the following?

- ☐ Chicken Pox
- ☐ Covid
- ☐ Diphtheria
- ☐ Hepatitis
- ☐ Lyme Disease
- ☐ Malaria
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Small Pox
- ☐ STD/STI
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Whooping Cough
- ☐ Other infectious virus (please specify): _____

Do you wear glasses or contact lenses? Yes No
Do you wear any dental appliances? Yes No

Do you have any implants? Yes No

Please list: _____

Do you wear any external hardware (i.e. insulin pump, hearing aid) Yes No

Please list: _____

For females only:

Do you have regular menstrual cycles? Yes No

Date of last menstrual cycle: ____/____/____

Do you have any of the following?

- ☐ Absence of menstruation
- ☐ Decreased bone density
- ☐ Endometriosis
- ☐ Ovarian cysts
- ☐ Painful menstruation

Do you take birth control? Yes No

If yes, please specify which type (pill, IUD, implant, etc.): _____

Have you been pregnant in the last 12 months? Yes No

If yes, please provide date of pregnancy _____

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Name: _____ Date: _____

Mental Health Screening:

Have you ever been diagnosed with mental illness? Yes No

Please list any mental health diagnoses: _____

_____

Do you currently take any medications for a mental illness? Yes No

Patient Health Questionnaire-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better of dead or of hurting yourself in some way	0	1	2	3

Total: _____

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Name: _____ Date: _____

General Anxiety Disorder Screening (GAD-7):

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total: _____

If you have any additional information you would like to provide, please us the space below:

_____

_____

_____

_____

All statements and answers in the above medical history are true and complete to the best of my knowledge. I have no abnormality, limitation, or restriction not mentioned in this record. I understand that this information is to help determine my fitness to participate, and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur. I consent to treatment by the certified athletic trainer on site.

Printed name: _____Date:_____
(last) (first) (middle)

Signature: _____ Date:_____

Signature of parent/guardian: _____ Date:_____
(Not required if student is 18 years or older)

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