

**Utica College Sports Medicine  
Annual Health Update**

09 10 11 12

Name: \_\_\_\_\_ Sport(s): \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
 UC Student ID # (9 digit) \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Year: So Jr Sr 5<sup>th</sup>  
 Home address/city: \_\_\_\_\_ Home phone: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
 Email \_\_\_\_\_  
 Insur Co \_\_\_\_\_ ID# \_\_\_\_\_ Plan/grp \_\_\_\_\_ Phone \_\_\_\_\_

**In the last year, have you had any of the symptoms? Explain below:**

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Dizziness, lightheadedness or passed out during or after exercise?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Chest pain, irregular heartbeat, or heart palpitations while exercising?                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Shortness of breath, cough, or trouble breathing?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Head injury or concussion?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Muscle, bone or joint injury (current or lingering injury)?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any surgeries?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has your weight changed more than twenty pounds?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have any existing medical problems? List below<br>(i.e. asthma, diabetes, allergies) | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you developed any new medical problems (i.e. car accident)?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Are you taking any prescriptions medications? List below.                                  | <input type="checkbox"/> | <input type="checkbox"/> |

Attach current insurance card. Each student-athlete must prove **insurance** to participate.  
 You must notify the Athletic Training Staff of insurance changes during the year.

**Student Athlete Signature:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

<b>Sports Medicine Staff Use:</b>				
Date _____	<i>Last year</i>	<i>Current year</i>		
Form reviewed by: <i>BP</i> _____	_____	_____	Ortho Scrn _____	n/a
ATC _____	<i>Pulse</i> _____	_____	Ins info _____	school
Clinician _____	<i>WT</i> _____	_____	Cleared by _____	
Other _____	<i>HT</i> _____	_____	Date _____	