

UNIVERSIT OF MAINE AT FORT KENT  
INJURY PROFILE

Please print clearly- Use pen or type

Date: _____		International Student: _____	
Name: _____		SS# _____	D.O.B.: _____
Sport playing: _____			
School Address: _____		City: _____	State _____ Zip _____
School Phone: (    ) _____			
<b>In case of an emergency, please contact:</b>			
Name: _____		Relationship: _____	
Address: _____		City: _____	State _____ Zip _____
Home Phone: (    ) _____		Work Phone: (    ) _____	
Personal physician: _____		Phone: (    ) _____	
Address: _____		City _____	State _____ Zip _____

Do you wear contacts? \_\_\_\_\_

Have you recently had "mono" or appendicitis or other acute illness? If so, give details. \_\_\_\_\_  
\_\_\_\_\_

Have you had a hernia? \_\_\_\_\_ Heart Murmur? \_\_\_\_\_

Any other heart conditions? \_\_\_\_\_  
Collapsed lung? \_\_\_\_\_ Are you epileptic? \_\_\_\_\_ Diabetic? \_\_\_\_\_  
Asthmatic? \_\_\_\_\_  
What medications do you now take and for what reason? \_\_\_\_\_  
\_\_\_\_\_

Do you have two functioning (working) eyes? \_\_\_\_\_ Kidneys? \_\_\_\_\_  
Do you have any history of kidney disease? \_\_\_\_\_  
Do you have allergies? \_\_\_\_\_ What? \_\_\_\_\_  
Date of immunizations: Measles \_\_\_\_\_ Rubella \_\_\_\_\_  
Tetanus- dipheria \_\_\_\_\_  
Do you have any medical illness which we should know about for you protection?  
\_\_\_\_\_

Please list your family medical History \_\_\_\_\_  
\_\_\_\_\_

Any pervious injuries that I should be aware of, this includes concussions?  
\_\_\_\_\_

Have you had any surgeries- if so for what and when? \_\_\_\_\_  
\_\_\_\_\_

## DENTAL HISTORY:

Symptoms	YES	NO	Comments
Do you have a dental cap?	YES	NO	
Have you ever had a tooth knocked out?	YES	NO	
Have you ever fractured a tooth?	YES	NO	
Do you wear orthodontic appliances or other dental appliances?	YES	NO	
Do you see a dentist on regular basis?	YES	NO	
Date of last dental exam:_____			

## DRUG, FOOD, SUPPLEMENTS AND MISCELLANEOUS AGENTS:

AGENT	Never	Rarely	Occasionally	Frequently
Vitamins	Never	Rarely	Occasionally	Frequently
Iron Supplements	Never	Rarely	Occasionally	Frequently
Diet Pills	Never	Rarely	Occasionally	Frequently
Sleeping Pills	Never	Rarely	Occasionally	Frequently
Laxatives	Never	Rarely	Occasionally	Frequently
Antihistamines	Never	Rarely	Occasionally	Frequently
Anti- inflammatory	Never	Rarely	Occasionally	Frequently
Anabolic Steroids	Never	Rarely	Occasionally	Frequently
Nutritional supplements Liquid/Powder	Never	Rarely	Occasionally	Frequently
Caffeine	Never	Rarely	Occasionally	Frequently
Alcoholic Beverages	Never	Rarely	Occasionally	Frequently
Tobacco (cigarettes,chew,ect.)	Never	Rarely	Occasionally	Frequently
Special Diets (Specify):	Never	Rarely	Occasionally	Frequently

## FINAL REVIEW

Final Review	Yes	No	Explain
1. Have you had or do you have any other medical problems injuries not listed on this form?	Yes	No	
2. Have you been advised to have any surgical procedure?	Yes	No	
3. Are there any additional health problems you would prefer to discuss privately?	Yes	No	
4. Is there any special protective equipment that you require or would like to have provided?	Yes	No	
5. Is there any reason that you are not able to participate athletics?	Yes	No	

**ALL OF THE PRECEDING INFORMATION IS COMPLETE AND HONEST TO THE BEST OF MY KNOWLEDGE:**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**THANK YOU FOR YOUR COOPERATION---IT IS FOR YOUR OWN PROTECTION**