Student Name: _____
BC Eagle ID: _____
Student Cell Phone: _____

BOSTON COLLEGE

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Demographics

Name:	DOB:
Biological Sex: Male or Female or Other	Eagle ID:
Gender Identity:	Preferred Pronouns:
Home address:	City:
State:	Zip Code:

Emergency Contact

Parent/Guardian Name:	Parent/Guardian Phone Number:
	Parent/Guardian Email:
Emergency Contact Name:	Emergency Contact Phone Number:
	Emergency Contact Email:

Medical History

Do you currently have OR have you ever had?	**Yes or No If yes, explain:**
Absence or a loss of a paired organ (eye, lung, kidney, ovary, testicle)	
Asthma, breathing difficulty, or coughing with exercise	
Heat related illness or muscle cramping with exercise	
Chest pain with exercise	
Heart racing or palpitations	
Lightheadedness, dizziness, or fainting with exercise	
Do you tire more quickly than others with exercise	
Diabetes	
Infectious mononucleosis	
COVID-19	
Epilepsy or seizures	
Recurrent headaches or migraines	
Any bleeding problems (abnormal bruising or bleeding)	
Anemia	
Blood clots or pulmonary embolism	
Hernia (umbilical, sports, inguinal, other)	
Stomach disease or appendicitis	
Kidney disease	
Liver disease	
Heart murmur or heart condition	
ADD/ADHD	

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An autoimmune disease (systemic lupus erythematosus, rheumatoid arthritis, other)	
Thyroid disease (hypothyroidism, hyperthyroidism)	
Mumps	
Rubella	
Chicken pox	
Meningitis	
Cancer	
Been admitted/Spent the night in the hospital	
Surgery (Bone, joint, wisdom teeth, appendix, hernia, etc.)	
Any post-surgical metal in your body? (Screws, pins, plates)	
Are you currently followed by a medical provider for a medical condition?	

Mental Health History

Do you currently have OR have you ever had?	**Yes or No If yes, explain:**
Have you been diagnosed with depression, anxiety, or any other mental health condition?	
Are you currently followed by a medical provider for a mental health condition?	

Female Only Health History

How old were you when you had your first menstrual period?	
When was your last menstrual period?	
How many periods did you have last year?	
Have you ever had a period of time where you didn't have your period for at least 3 months?	
Have you ever been on birth control (pills, patch, NuvaRing, Nexplanon implant, IUD)?	
Do you have any issues with your periods (pain, heavy bleeding, endometriosis, other)?	
Do you have frequent urinary tract infections (UTIs)?	

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Male Only Health History

Do you experience any unusual discharge?	
Do you have any testicular pain or masses?	

Injury History

Have you had any of the following injuries?	**If yes, explain and include dates:**
Concussion (list all dates)	
Head or Face (fracture, surgery, other)	
Neck (strain, fracture, "stinger/burner", surgery, pinched nerve, other)	
Shoulder (dislocation, subluxation, rotator cuff injury, other)	
Arm/Elbow (sprain, strain, fracture, dislocation, tendinitis, bursitis, other)	
Wrist/Hand/Fingers (sprain, fracture, tendinitis, carpal tunnel, other)	
Chest/Ribs (fracture, lung/heart injury, other)	
Abdomen (Internal organ injury, sports hernia, strain, other)	
Back (strain/sprain, chronic pain, pinched nerve, disc injury, scoliosis, surgery, other)	
Hip/Thigh (fracture, strain, bruise, bursitis, labral injury, sacroiliac joint pain, other)	
Knee (ligament sprain, cartilage injury, bursitis, surgery, Osgood Schlatter's, other)	
Lower leg (fracture, shin splints, compartment syndrome, other)	
Ankle (sprain, fracture, tendinitis, instability, other)	
Foot (sprain, fracture, plantar fasciitis, heel spur, other)	
Toes (turf toe, fracture, bunions, other)	

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Vision History

	Yes or No **If yes, explain:**
Do you wear glasses or contacts lenses during sports participation?	
	If yes, when was your last eye exam?
Have you ever suffered an eye injury?	
Do you have any type of eye trouble or condition?	
Is your color vision abnormal?	

Dental History

	Yes or No **If yes, explain:**
Do you have any chipped, loose, or missing teeth?	
Do you wear a dental appliance (retainer, orthodontic, other)?	
Do you have any type of dental condition?	
Have you had your wisdom teeth or tonsils removed?	

Substance History

	If yes, explain:
Do you smoke or vape?	
Do you consume alcohol?	
	If yes, how many drinks per week?

Diet History

Are there any food groups you choose not to eat (meat, dairy, gluten)?	
Does your weight affect the way you feel about yourself?	
Are you trying to gain or lose weight?	
Do you frequently think about reducing your weight, have concerns about your body image, or have been told you have an eating disorder?	

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Allergies and Medications

Do you have any known allergies to medications?	
Do you have any known allergies to food?	
Do you have any allergies to insect bites or stings?	
Please list any other allergies:	
Please list all current medications with dosages and over the counter supplements (including vitamins):	
Do you have an Epi-Pen? Reason?	

Family History

Does anyone in your family have any of the following conditions:	**Yes or no? If yes, which family member?**
Heart disease (coronary artery disease, atrial fibrillation, other)	
High blood pressure	
Sickle cell anemia or trait	
Sudden death before the age of 50	
Marfan's syndrome	
Diabetes	
Hemophilia	
Stroke	
Seizures or epilepsy	
Eating disorders	
Depression, anxiety, or other mental health condition	

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General Information

	Yes or No If yes, explain:
Do you currently need any type of bracing, taping, or other special padding for sport?	
Have you had an illness or injury in the past 12 months that is not listed above?	
Have you used/Are you using any performance enhancing supplement or drug?	
Do you know of any health reason that would put you at risk if participating in a sport at the current time?	

Health Insurance Information

Insurance must be updated annually and when there is a change. Enter your insurance information on your health services portal.
Please upload a copy of the front & back of your insurance card to your health portal.

Authorization and Consent

A parent/guardian must acknowledge and sign this section this section if the student is under the age of 18 on the first day of classes.

I give Boston College (BC) Health Services (UHS) permission to examine and treat me during my enrollment at BC. I understand that UHS providers within this organization may discuss my care with the clinic to allow for adequate care and management. I understand if specialty care is needed, UHS will provide a referral. This information is for UHS use and will not be released to a third party without your consent. **I certify that the information provided is complete and accurate. I am aware of the Health Services privacy policy located on the UHS website:** www.bc.edu/uhs

Student name:	
Student signature:	Date:
Parent/Guardian signature:	Date:

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