

Instructions: We require you to complete this medical history form and return it to the Athletic Training Department prior to participation.
Please Print:

Name: Last First M.I. Telephone Number

Local address/Street City State/Zip

Month/Day/Year of Birth Single/Married Social Security Number

In an emergency notify: Name/Relationship Address Telephone Number

Personal Physician Address Telephone Number

Hospital Preference (If a local Student-Athlete)

Insurance Company Name: _____

Group Name: _____ **Group Number:** _____

Name of Insured: _____

Social Security # relationship

Personal Health History

Please check if you have had any of the following. Give date of illness, operation, or injury, and date of last treatment.

Alcohol Abuse	Ear trouble	Meningitis
Amnesia	Eating disorder	Menstrual problems
Appendicitis	Encephalitis	Migraine headaches
Asthma	Exercise Induced Asthma	Mumps
Birth Defects	Eye trouble	Nervous/Mental condition
Blood Clots	Fainting	Pneumonia
Bronchitis	Frequent headaches	Recurrent headaches
Cancer	Gall Bladder trouble	Rheumatic fever
Car or Air Sickness	Hearing defect/loss	Rubella
Chest Pain	Heart problem	Scarlet fever
Chicken Pox	Hemorrhoids	Seizure disorder
Chronic Cough	Hepatitis	Sexually transmitted disease
Concussion	Hernia	Sickle cell anemia
Convulsions	High Blood pressure	Sinus trouble
Diabetes	Hypoglycemia	Stomach/intestinal problems
Diphtheria	Kidney disease	Tuberculosis
Depression	Malaria	Ulcers
Drug abuse	Measles	

Head and Neck History: Check and write brief description

yes no

Have you ever been unconscious? (If yes, check which one) a. Knocked out _____ b. Blacked out after accident, _____		
Have you ever had a concussion? (If yes): How many times? _____ How long to make a complete recovery? _____ Date of last concussion? _____		
Have you ever had a skull/or spine fracture?		
Have you ever had a herniated disc?		
Have you ever had a "pinched nerve"?		

General Musculoskeletal

yes no

Have you ever fractured a bone (includes stress fractures)? Which bone(s)?		
Have you ever had a musculoskeletal surgery? Where?		
Have you ever had a pin, plate, or screw placed in joint? Where?		
Have you had a sprain or strain to a muscle or ligament within the last 2 yr.?		

Allergies (are you allergic to?)

Anti-Inflammatory	Hay Fever	Tetanus Antitoxin/serum
Aspirin	Insect Bites/Stings	Any food
Codeine	Penicillin	Any other drug
Cortisone	Sulfa	Other

Heat (have you ever experienced any of the following, list when and how long it took to recover)

Frequent dehydration/Heat syncope (fainting)	Heat Cramps
Heat Stroke	Heat Exhaustion

List any medications taken regularly:

Family History: (Have any of your relatives ever had any of the following?)

	Age	State of health	Age of Death	Cause of Death		yes	Relationship	Explain
Father					Tuberculosis			
Mother					Diabetes			
Brothers					High Blood Press			
					Heart Disease			
					Arthritis			
Sisters					Hay Fever			
					Asthma			
					Cancer			

Immunization Record: (List the date last completed)

Tetanus/Diphtheria		Measles, Mumps, and Rubella	
Influenza		Hepatitis B Vaccine (Have you completed the series?)	

Foreign Travel Vaccines, Other

Tuberculin Skin Test

Immunization	Date	Date	Results
		<i>Chest</i>	<i>X-ray (if skin test positive)</i>
		<i>Date</i>	<i>Results</i>

List any other physical or mental concerns not already noted above:

Signature and Consent (if student is under 18, both parent/guardian and student must sign)

I certify that the medical facts stated above are true to the best of my knowledge.

I agree to pay any charge for service not covered by university fees or by insurance.

I hereby consent to the release of medical information to the appropriate university representatives.

Signature of student

Date

Signature of parent or guardian

Date