Sports Medicine/Medical History

I. Personal Information (Please Print)

Name: _____ Date: _____

Date of Birth: _____ Social Security #: _____

Home Phone Number: (____)_____ Cell Phone Number: (____)_____

Home Address: _____ Name of Medical Insurance: _____

City State Zip_____ Policy Number: _____

Primary Care Physician: _____ Phone #:(____)_____

Address: _____City State Zip:_____

Sport: _____

Family History: List serious illnesses of close relatives, example: Diabetes, Heart Disease, Tuberculosis, etc.:

_____

_____

II. Hospitalizations/Surgery

Y / N Are you currently under medical supervision?
If yes, explain_____
Y / N Have you ever had surgery?
Date: _____ Reason_____
Date: _____ Reason_____
Date: _____ Reason_____
Date: _____ Reason_____
Y / N Have you ever been hospitalized for a reason other than surgery?
Date: _____ Reason_____
Date: _____ Reason_____
Y /N Have you ever been advised to have surgery not yet performed?
If yes, why _____
Y /N **I give the Clarendon College Athletics permission to receive the medical record for this surgery.

If yes, Sign and Date_____

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III. Medications

Y / N Do you regularly use any prescription medication (e.g., inhaler, seizure medication, oral contraceptives)? If yes, explain _____

Y / N Do you regularly use any non-prescription medication (e.g., Advil, Sudafed)?
If yes, explain _____

Y / N Do you regularly take nutritional supplements?
If yes, describe _____

Y / N Do you use narcotics, anabolic steroids, or street drugs?
If yes, describe _____

Y / N Do you use tobacco products?
If yes, describe _____

IV. Allergies

Y / N Aspirin
Y / N Asthma
Y / N Dust, Pollen
Y / N Food (specify) _____
Y / N Insect Stings (specify) _____
Y / N Novocain
Y / N Penicillin
Y / N Sulfa Drugs
Y / N TB Tine Test
Y / N Tetanus Serum
Y / N Other Drugs (specify) _____

V. Immunizations

Y / N Flu Date: _____
Y / N Hepatitis B Date: _____
Y / N Measles Date: _____
Y / N Mumps Date: _____
Y / N Rubella Date: _____
Y / N TB Test Date: _____
Y / N Tetanus Date: _____

VI. Illnesses (GIVE DATE IF WITHIN THE PAST 3 YEARS)

Y / N Chicken Pox Date: _____
Y / N Diabetes Date: _____
Y / N Headaches (frequent) Date: _____
Y / N Measles Date: _____
Y / N Mononucleosis Date: _____
Y / N Mumps Date: _____
Y / N Pneumonia Date: _____
Y / N Rheumatic Fever Date: _____
Y / N Scarlet Fever Date: _____
Y / N Stomach Disorder Date: _____
Y / N Tuberculosis Date: _____
Y / N Other (specify) Date: _____

VII. Cardiovascular System

Y / N Have you ever fainted during exercise?
Y / N Have you ever had chest pains during exercise or after exercise?
Y / N Have you ever been told that you might have high blood pressure?
Y / N Have you ever been told that you have a heart murmur?
Y / N Have you ever had racing of your heart or skipped heartbeats?
Y / N Has anyone in your family died of heart problems or a sudden death before the age of 50?
If you answered yes to any of the above questions please explain
_____
_____

VIII. Musculoskeletal System

Have you ever injured any of the following extremities that caused you to miss significant playing time (a week or more)?
Y / N Hip Date: _____ Explain: _____
Y / N Abdomen / Groin Date: _____ Explain: _____
Y / N Thigh Date: _____ Explain: _____
Y / N Knee Date: _____ Explain: _____
Y / N Shin / Calf Date: _____ Explain: _____
Y / N Ankle Date: _____ Explain: _____
Y / N Foot / Toes Date: _____ Explain: _____
Y / N Skull / Face / Nose Date: _____ Explain: _____
Y / N Teeth / Jaw Date: _____ Explain: _____
Y / N Neck Date: _____ Explain: _____
Y / N Back Date: _____ Explain: _____
Y / N Shoulder Date: _____ Explain: _____
Y / N Upper Arm Date: _____ Explain: _____
Y / N Elbow Date: _____ Explain: _____
Y / N Forearm Date: _____ Explain: _____
Y / N Wrist Date: _____ Explain: _____
Y / N Hand / Fingers Date: _____ Explain: _____

IX. Neurological System

Y / N Have you ever had a head injury?
Date: _____ Explain: _____
Y / N Have you ever been knocked unconscious?
Date: _____ Length of unconsciousness _____Explain: _____

Y / N Have you ever had a seizure?
Date: _____ Explain: _____
Y / N Have you ever had a stinger, burner, or pinched nerve?
Date: _____ Explain: _____

X. Heat Problems

Y / N Have you ever had muscle spasms or cramps caused by heat? Date: _____
Y / N Have you ever been dizzy or fainted in the heat? Date: _____

XI. For Women Only

Date of last menstrual period _____
Date of last gynecological exam / pap smear_____
My periods are now: (circle one) Regular (every 24-35 days)
Irregular (every 36 days or more)
Absent (no periods for the past 3 months)
Y / N Do you have any gynecological problems (e.g., cramps, PMS, discharge)?
If yes, explain _____
Y / N Have you ever missed periods for 6 months or more?
If yes, explain _____

XII. Other Medical Conditions

Do you currently have, or in the past had:

Y / N Anemia
Y / N Calcium Deposit
Y / N Eye injury or other eye problem
Y / N Hearing Loss
Y / N Severe tooth or gum trouble
Y / N Skin problems (rash, acne, boils)

Do you have loss or seriously impaired function of any paired organ?

Y / N Ear
Y / N Eye
Y / N Kidney
Y / N Ovary
Y / N Testicle

Do you wear?

Y / N Contact Lens
Y / N Eyeglasses
Y / N Dental appliance
Y / N Corrective brace or support

Y / N Do you know of or believe there is any health reason that should prevent you from participation in intercollegiate athletics?
Explain: _____

_____

I certify that the answers to the preceding questions are correct and true. I understand that passing the physical exam does not necessarily mean that I am physically qualified to engage in intercollegiate athletics, but only that the examiner did not find a medical reason to disqualify me from participation.

_____
Name Date

MEDICAL CONSENT

Permission is hereby granted to the attending physician, CC Sports Medicine Staff, or other medical personnel to proceed with medical or, minor surgical treatment, X-ray examination, and immunizations. In the event of serious injury or illness, I understand that an attempt will be made by the appropriate medical personnel to contact my parents or legal guardian. If medical personnel are not able to communicate with the responsible party the treatment necessary for my health will be provided.

_____

Student Athlete's Signature Date

_____

Print Name

IN CASE OF EMERGENCY, CONTACT:

1. Name: _____ Relationship: _____

Address: _____ City:_____ St:_____ Zip:_____

Phone: Home _____ Business:_____ Cell: _____

Secondary Emergency Contacts:

2. Name: _____ Cell Number: _____

Relationship: _____

3. Name: _____ Cell Number: _____

Relationship: _____