

ATHLETE'S MEDICAL HISTORY

NAME: _____ SEX: _____ AGE: _____ DATE OF BIRTH: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY ZIP

HOME PHONE #: _____ CELL PHONE #: _____

SPORTS: _____ MCC STUDENT ID#: _____

CONTACT PERSON IN CASE OF EMERGENCY:

NAME: _____ PHONE#: _____ RELATIONSHIP: _____

NAME: _____ PHONE#: _____ RELATIONSHIP: _____

HAVE YOU EVER HAD: (CHECK THOSE THAT APPLY)

_____ ALLERGIES	_____ HIGH/LOW BLOOD PRESSURE	_____ RADIATION/X-RAY TREATMENT
_____ ANKLE PROBLEMS	_____ EYE PROBLEMS	_____ MONO
_____ ARTHRITIS	_____ FAINTING SPELLS	_____ MIGRAINE
_____ ASTHMA	_____ HEAD/NECK PROBLEMS	_____ KNEE PROBLEMS
_____ BACK TROUBLE	_____ EPILEPSY	_____ RHEUMATIC FEVER
_____ BLACKOUTS	_____ HEARING PROBLEMS	_____ SEIZURES
_____ BLOOD DISORDER	_____ HEART PROBLEMS/MURMURS	_____ SHOULDER PROBLEMS
_____ BROKEN BONES	_____ HEPATITIS	_____ SINUS PROBLEMS
_____ COUMMUNICABLE DISEASE	_____ HERNIA	_____ STREP/SORE THROATS
_____ CONCUSSION	_____ KIDNEY DISEASE	_____ ULCER
_____ DIABETES	_____ MEASLES	_____ OTHER: SPECIFY

EXPLANATION: _____

PREVIOUS SURGERIES OR HOSPITAL ADMISSIONS: (IF NONE, WRITE NONE)

	<u>TYPE</u>	<u>HOSPITAL</u>	<u>DATE</u>
NON-ATHLETIC RELATED:			
1.	_____	_____	_____
2.	_____	_____	_____

ATHLETIC RELATED:

1.	_____
2.	_____

ANY PREVIOUS INJURIES:

	<u>TYPE</u>	<u>HOSPITAL</u>	<u>DATE</u>
NON-ATHLETIC RELATED:			
1.	_____	_____	_____
2.	_____	_____	_____

ATHLETIC RELATED:

- _____
- _____

HAVE YOU EVER USED ORTHOPEDIC SUPPORTS/BRACES? YES NO

PURPOSE: _____

PRESCRIBING PHYSICIAN: _____

DO YOU WEAR GLASSES? YES NO DO YOU WEAR CONTACT LENSES? YES NO

MEDICATIONS YOU ARE CURRENTLY ON:

	<u>TYPE</u>	<u>PURPOSE</u>
1.	_____	_____
2.	_____	_____

ANY OTHER MEDICAL PROBLEMS THAT OUR STAFF SHOULD KNOW ABOUT? FOR EXAMPLE: ALLERGY TO BEE STING.

EXPLAIN: _____

PHYSICIAN: _____ PHONE #: _____

ADDRESS: _____

PREFERRED HOSPITAL: _____ INSURANCE: _____

PROVIDER: _____ PHONE #: _____

ADDRESS: _____

PROVIDER: _____ PHONE #: _____

ADDRESS: _____

I DECLARE ALL THE ABOVE ANSWERS TO BE TRUE TO THE BEST OF MY KNOWLEDGE:

STUDENTS SIGNATURE _____ DATE _____

NURSE/DOCTOR NOTES: _____

