

# Converse College Sports Medicine

## New Athlete Medical History Form

Name _____	Sex _____	Age _____	Date of Birth _____
Social Security # _____	Sport(s) _____		
Home Address _____			Home Phone# _____
Street Address	City	State	Zip
Personal Physician _____		_____	
Name	Address	Phone #	
<b>Emergency Contact:</b>			
Name _____	Relationship _____	Phone# _____	

**EXPLAIN "YES" ANSWERS ON SPACE PROVIDED**

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. Have you ever been hospitalized overnight? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had surgery? When? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you presently taking any medication or pills (prescription or nonprescription)? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have asthma? Use an inhaler? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any allergies (medicine, bees, etc.)? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve performance? _____                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever passed out during exercise? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever been dizzy during or after exercise? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had chest pain during or after exercise? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you tire more quickly than your friends during exercise? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had or currently suffer from high blood pressure? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever been told you have a heart murmur? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever had racing of your heart or skipped heartbeats? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Has anyone in your family died of heart problems or a sudden death before age 50? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you have any skin problems (itching, rashes, acne)? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had a head injury? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever been knocked out or unconscious or lost your memory? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had a seizure? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have frequent or severe headaches? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you ever had a burner, stinger, or pinched nerve? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you ever had numbness or tingling in your arms, hands, legs, or feet? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you ever had heat or muscle cramps? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you ever been dizzy, become ill, or passed out in the heat? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you have problems breathing or do you cough during or after exercise? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you use any special equipment (pads, braces, neck roll, eye guard)? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you had any problems with you eyes or vision? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you wear glasses or contacts or protective eye wear? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you experienced a loss of a kidney? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Have you ever had any other medical problems (infectious, mononucleosis, diabetes, etc.)? _____                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you had a medical problem or injury since your last evaluation? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever sprained/strained, dislocated, fractured, broken, or had repeated swelling or other injuries of any bones or joint |                          |                          |

Explain injury and give date of injury. \_\_\_\_\_

- |                               |                                    |                                    |                                |                                  |                                |
|-------------------------------|------------------------------------|------------------------------------|--------------------------------|----------------------------------|--------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Shoulder  | <input type="checkbox"/> Wrist     | <input type="checkbox"/> Hip   | <input type="checkbox"/> Forearm | <input type="checkbox"/> Chest |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Hand      | <input type="checkbox"/> Thigh | <input type="checkbox"/> Ankle   |                                |
| <input type="checkbox"/> Back | <input type="checkbox"/> Elbow     | <input type="checkbox"/> Shin/Calf | <input type="checkbox"/> Knee  | <input type="checkbox"/> Finger  |                                |

32. When was your last tetanus shot? \_\_\_\_\_ When was your last MMR immunization? \_\_\_\_\_  
 When was your last DPT immunization? \_\_\_\_\_ Hepatitis B immunization? \_\_\_\_\_
33. When was your first menstrual period? \_\_\_\_\_ When was your last menstrual period? \_\_\_\_\_

**Explain "YES" Answers:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*I hereby state, to the best of my knowledge, my answers to the above questions are correct and complete.*

Signature of Student-Athlete \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_  
 (If Student-Athlete is not 18 years of age)