ATHLETE'S MEDICAL HISTORY

Date: ____________________ Sports: ___________________________ ___________________________

Name: ____ MCC Student ID#: ____________________

Sex: M ____ F _____ Age: ______ Birth Date: ____________________

Address: ____ ___________________________ _____________
Street City Zip

Home Phone #: _________________________________ Cell #: _________________________________

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)

	Type	Hospital	Date
Non-Athletic Related			
	___________________________	_________________________________	_____________
	___________________________	_________________________________	_____________
Athletic Related			
	___________________________	_________________________________	_____________
	___________________________	_________________________________	_____________

Any Previous Injuries

	Type	Hospital	Date
Non-Athletic Related			
	____________	____________	______
	____________	____________	______
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

Type	Purpose
____________________	____________________
____________________	____________________

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: ____