Rockford College
Athletics Medical History Form

Demographics:
Name _____ Date _____

Sport _____ Position _____ SS#_____

Date of Birth _____ Age _____

Family History:
Has anyone in your immediate (nuclear) family had any of the following: Please circle yes or no.

Heart Disease	Yes	No	Diabetes	Yes	No
High Blood Pressure	Yes	No	Cancer	Yes	No
Stroke	Yes	No	Tuberculosis	Yes	No
Sudden Death (before 50)	Yes	No	Asthma	Yes	No
Epilepsy	Yes	No	Gout	Yes	No
Migraine Headaches	Yes	No	Marfan's Syndrome	Yes	No
Eating Disorder	Yes	No	Sickle Cell	Yes	No

Personal History:
1. Have you ever been hospitalized? Yes No
   Have you ever had surgery? Yes No
   Are you presently under a doctor's care? Yes No
   Please explain and give dates for all "Yes" answers: _____
_____
_____

2. Please list any medications you are currently taking and for what conditions, including over the counter medications and supplements.
_____
_____
_____

3. Please list any allergies. _____
_____
_____

4. Have you ever had a head injury or a concussion? Yes No
   Have you ever been knocked out or unconscious? Yes No
   Have you ever had a seizure? Yes No
   Have you ever had a stinger, burner or pinched nerve? Yes No
   Do you have recurring headaches or migraines? Yes No

Please explain and give dates of “yes” answers: _____

_____

_____

_____

5. Have you ever had heat cramps, heat exhaustion, heat illness or muscle cramps? Yes No

6. Do you have a history of asthma? Yes No

7. Have you ever had the chicken pox? Yes No
   If so, at what age: _____

8. Have you ever had the mumps or measles? Yes No

9. Are you missing an eye, kidney, lung, or testicle? Yes No

10. Do you have any problems with your eyes or vision? Yes No

11. Have you had any other medical conditions (mononucleosis, diabetes, anemia)? Yes No

12. Have you ever taken supplements for improved performance? Yes No

13. Are you presently taking any supplements for diet or performance? Yes No
    If “Yes” then what substances: _____

14. Do you have any trouble breathing or do you cough during practice? Yes No

15. Do you have any skin problems (itching, rash, acne)? Yes No

Explain all yes answers for questions 5-15: _____

_____

_____

_____

_____

_____

_____

16. What is the lowest weight you have been at in the last year _____

    Highest? _____ What is your ideal weight? _____

17. Have you ever fainted during or after exercise?	Yes	No
Have you ever been dizzy during or after practice?	Yes	No
Have you ever had chest pain during or after exercise?	Yes	No
Have you ever had high blood pressure?	Yes	No
Have you ever been told you have a heart murmur?	Yes	No
Have you ever had an echocardiogram or an EKG?	Yes	No
Has your heart ever raced or skipped a beat?	Yes	No
Has anyone in your family died of heart problems or of a sudden death before the age of 50?	Yes	No

Explain all "Yes" answers for question 17: _____

_____

_____

_____

_____

18. Have you ever sprained/strained, dislocated, fractured, or had swelling or other injury of any bones or joints in your body? Explain any "Yes" answers.

Head/neck	Yes	No	_____
Shoulder	Yes	No	_____
Elbow/arm	Yes	No	_____
Wrist/hand/fingers	Yes	No	_____
Back	Yes	No	_____
Hip/thigh	Yes	No	_____
Knee	Yes	No	_____
Shin/calf	Yes	No	_____
Ankle/foot/toes	Yes	No	_____

Would you like to speak to a medical staff member regarding any topics or concerns? (for example nutrition, drugs, heart problems, weight gain/loss, sexual diseases, concussions, etc…) If "Yes" then what topic? _____	Yes	No

Please sign:

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

_____

Athlete's signature Date signed

_____

Parent's signature if under 18 years of age Date signed