OBERLIN
COLLEGE & CONSERVATORY

Intercollegiate Sports Medical History

Only for students interested in athletics

Please print or type.

Questions?
440-775-8514

Return to:
Director of Sports Medicine
Department of Athletics and Physical Education
200 Woodland St.
Oberlin, OH 44074

Or fax to: 440-775-8616

DEADLINE: July 1, 2010

The information you provide on this form is strictly for the use of the Sports Medicine Department and will not be released to anyone without your knowledge and consent. You must submit additional copies of the following forms in this book: Medical History/Physical Exam (pages 41-43) and Insurance Information (page 47) to the Sports Medicine Department.

Name: Date of Birth:

Last First Middle Month/Date/Year

Sport(s): Age: Social Security Number (if available):

Home Address: Home Telephone:

Number and Street (Country/Area Code) Number

City State Zip Country

Campus Residence (if known):

Campus Telephone (if known): Campus OCMR box (if known):

Have you ever *If yes, please explain below.*

had surgery? ☐ Yes ☐ No

passed out during or after exercise? ☐ Yes ☐ No

been told you have a heart murmur? ☐ Yes ☐ No

had racing of your heart or skipped beats? ☐ Yes ☐ No

Has anyone in your family died of heart problems or sudden death before the age of 50? ☐ Yes ☐ No

Have you ever had a head injury? ☐ Yes ☐ No

If yes, explain, including number.

Have you ever been knocked unconscious? ☐ Yes ☐ No

If yes, explain.

Have you ever had a seizure? ☐ Yes ☐ No

If yes, explain, including number.

Are you currently taking any medications? ☐ Yes ☐ No

If yes, list medications.

(Please complete reverse side.)

Intercollegiate Sports Medical History *(continued)*

Do you or anyone in your family have a history of sickle cell trait/anemia? ☐ Yes ☐ No

Do you want to be tested for sickle cell trait/anemia at your cost? ☐ Yes ☐ No

Have you been diagnosed with ADD or ADHD? ☐ Yes ☐ No

If yes, name of physician and treatment dates. _____

If you answered yes, do you take medication for ADD/ADHD? ☐ Yes ☐ No

If yes, specify medication. _____

If you have a history of allergies, do you require the use of emergency medication? ☐ Yes ☐ No

If yes, specify medication. _____

If you have a history of asthma, do you require the use of emergency medication? ☐ Yes ☐ No

If yes, specify medication. _____

If you have a history of diabetes, do you require the use of medication? ☐ Yes ☐ No

If yes, specify type and form of medication. _____

Females only: Do you have a history of menstrual irregularities? ☐ Yes ☐ No

If yes, describe. _____

Date of last tetanus shot: ____ / ____ / ____
mo. day year

Have you ever sprained, strained, dislocated, fractured, or had repeated swelling of any of the following areas?
If yes, please explain below.

Head	☐ Yes	☐ No	_____
Neck	☐ Yes	☐ No	_____
Chest	☐ Yes	☐ No	_____
Shoulder	☐ Yes	☐ No	_____
Elbow	☐ Yes	☐ No	_____
Forearm	☐ Yes	☐ No	_____
Wrist	☐ Yes	☐ No	_____
Hand	☐ Yes	☐ No	_____
Back	☐ Yes	☐ No	_____
Hip	☐ Yes	☐ No	_____
Thigh	☐ Yes	☐ No	_____
Knee	☐ Yes	☐ No	_____
Ankle	☐ Yes	☐ No	_____
Calf	☐ Yes	☐ No	_____
Foot	☐ Yes	☐ No	_____

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

Student's Signature Date