# Emmanuel College Athletic Department

## Initial Medical History Form
## (New & Transfer Athletes)

**Personal Information:**

Name:_________________________________________ DOB: ___/___/____ Sex:______
Last First Middle

Street Address:_____________________________________________________________

City: ______________________________ State:______________ Zip Code: ____________

Phone: ______________________________ SS# __________________________________

Sport(s): ______________________ Position(s): ____________________________________

Circle one: FR SO JR SR

**In case of emergency, contact:**

1) Name: ___________________________________ Relationship: __________________
Phone (Home): _____________________ Phone (Work/Cell): ______________________

2) Name: ___________________________________ Relationship: __________________
Phone (Home): _____________________ Phone (Work/Cell): ______________________

**Family Physician:**

Name: ________________________________________ Phone: _______________________

Street Address: _______________________________________________________________

City: _________________________________ State: _________ Zip Code: _____________

**Family History:**

Has anyone in your family (parents, siblings, grandparents, etc.) ever had any of the following, resulted in death from any of the following, or had complications due to any of the following? If so, please list on this chart. Please be specific (i.e. grandmother on father's side, etc.)

| Medical Condition | Family Member | Age at death (if applicable) |
|---|---|---|
| Diabetes | | |
| Drug/Alcohol Dependency | | |
| Epilepsy | | |
| Gout | | |
| Heart Disease | | |
| Hemophilia, Sickle Cell Disease | | |
| High Blood Pressure/Hypertension | | |
| Kidney Stones | | |
| Leukemia | | |
| Marfan's Syndrome | | |
| Sudden Death before age 50 | | |
| Thyroid Disease/Goiter | | |
| Tuberculosis | | |

**Personal History:** Do you have or have you ever had any of the following medical conditions?

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Anemia | | | Hernia | | |
| Appendicitis | | | High/Low Blood Pressure | | |
| Arthritis | | | Hypoglycemia **(see below)** | | |
| Asthma **(see below)** | | | Immune Deficiency | | |
| Bladder Illness | | | Indigestion/Heartburn | | |
| Bleeding Tendencies | | | Kidney Disease/Injury | | |
| Breathing Problems | | | Liver Disease/Injury | | |
| Bronchitis | | | Lung Disease | | |
| Cancer | | | Measles | | |
| Chest Pain | | | Menstrual Disorders | | |
| Chicken Pox | | | Migraines | | |
| Congenital Heart Disease | | | Mononucleosis | | |
| Congestive Heart Failure | | | Mumps | | |
| Cytomegalovirus (CMV) | | | Pacemaker | | |
| Diabetes **(see below)** | | | Palpitation of the heart | | |
| Dizzy Spells | | | Phlebitis | | |
| Emotional Disorders | | | Pneumonia | | |
| Emphysema | | | Polio | | |
| Epilepsy | | | Pregnancy | | |
| Excessive Bleeding | | | Rheumatic Fever | | |
| Eye Disease or Injury | | | Seizure Disorder/Epilepsy | | |
| Fainting Spells | | | Sickle Cell Anemia | | |
| Feeding Disorder | | | Spleen Illness/Injury | | |
| Frequent Headaches | | | Stomach Trouble | | |
| Frequent Nausea/Vomiting | | | Stroke | | |
| Glaucoma | | | Swallowing Problems | | |
| Hearing Problems/Deficiencies | | | Thyroid Disease | | |
| Heart Problem/Disease | | | Tuberculosis | | |
| Hepatitis | | | Vision Problems | | |

**Diabetic/Hypoglycemia History (if you answered YES above):**

- Diabetics Only: Were you diagnosed with Type I or Type II Diabetes? _______
  - When? ____________
  - How often do you experience high blood sugar? _______________________
- Hypoglycemics Only: When were you diagnosed with hypoglycemia? ____________
- Both diabetics and hypoglycemics:
  - How often do you monitor your blood glucose level? _______________________
  - How often do you experience low blood sugar? _______________________

❖ **Continued on next page**

**Diabetic/Hypoglycemia History (continued):**

- If you are currently taking any medications, please fill in the information below:

**Medication** **Form** **Dosage** **Frequency**

___________________________________________________________________________

___________________________________________________________________________

____________________________________________

- Please list precautions you take and/or other information not already mentioned.

___________________________________________________________________________

______________________________________________________

**Asthma History (if you answered YES above):**

- What type(s) of asthma do you have (i.e. childhood, exercise-induced, nocturnal, etc)? _________________________________________ When were you diagnosed? _________
- How many attacks have you had in the past 24 months? ___________
  - List dates and explain what happened: ___________________________________

    ___________________________________________________________________

    ______________________________________________________

- List all medications used to treat your condition(s):

**Medication** **Form** **Dosage** **Frequency**

___________________________________________________________________________

___________________________________________________________________________

____________________________________________

**Cardiovascular History/Risk:**

| | YES | NO | DATE(S) |
|---|---|---|---|
| Have you ever had chest pain and/or shortness of breath during or after exercise / practice? | | | |
| Have you ever felt dizzy, lightheaded, and/or passed out during or after exercise / practice? | | | |
| Have you ever had the feeling of your heart racing or skipping beats during or after exercise / practice? | | | |
| Do you get tired more quickly than your teammates / friends do during exercise / practice? | | | |
| Have you ever been told that you have a heart murmur? | | | |
| Has any family member or relative died of heart problems and/or of sudden death before age 35? | | | |
| Has a physician ever denied or restricted your participation in sports due to any heart problems? | | | |
| Have you ever had an electrocardiogram (EKG) of your heart? | | | |
| Have you ever been told that you have / had high blood pressure? | | | |
| Have you even been told that you have / had high blood cholesterol? | | | |

**Explain all YES answers here:** ___________________________________________

___________________________________________________________________________

______________________________________________________

**Allergies:** Are you allergic to any of the following? Please explain.

| | YES | NO | Explain/Reactions |
|---|---|---|---|
| Insect Bites/Stings | | | |
| Tapes/Adhesives | | | |
| Iodine/Betadine | | | |
| Latex | | | |

| | | | |
|---|---|---|---|
| Chlorine | | | |
| Penicillin | | | |
| Sulfa | | | |
| Codeine | | | |
| Aspirin/Anti-Inflammatories | | | |
| Other drugs (list on right) | | | |
| Foods (list to right) | | | |
| All others (list to right) | | | |

Do you have an Epi-Pen for allergic reactions? **YES___ NO___**

**Other Medications:** Please list below any prescribed medications you are currently on (besides those previously mentioned), the dosage/frequency, ***and*** the purpose of those medications.

| Medication Name | Dosage & Frequency | Purpose |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Heat Illnesses**

- Have you ever been pulled from participation (practice or game) because of a heat-related illness? This includes dehydration, muscle cramps, heat exhaustion & stroke. **YES___NO___**
- Have you ever been hospitalized due to a heat-related illness? **YES___ NO___**
- If you answered yes to either question, please describe below the nature of illness and date of illness/hospitalization to the best of your ability. ______________________________________

  ______________________________________________________________________________________________

  ____________________________________________________________________

**Concussions**

- Have you ever been told you suffered a concussion? **YES___ NO___**
- If so, when was your last concussion? __________________
- Were you seen by a doctor? **YES___ NO___**
- Have you been hospitalized, knocked out, unconscious, or suffered memory loss due to a concussion? **YES___ NO ___**
- Did you miss playing time due to a concussion? If so, how much? _______________
- If so, please describe the nature of the concussion to the best of your ability.________________

  ______________________________________________________________________________________________

  ____________________________________________________________________

**Internal Injuries/History:**

- Were you born WITHOUT a complete set of paired organs (eyes, kidneys, ovaries/testes, lungs)? If so, please list here. _______________________________________________________
- Have you ever had surgery to repair/remove any organ (hernia, tonsils, appendix, spleen, etc)? If so, please describe below.

  **Date** **Organ Removed/Repaired** **Time of Hospitalization**

  ______________________________________________________________________________________________

  ____________________________________________________________________

**Orthopedic Injuries:** Please make note of injuries to any of the following parts of the body.

| Area of Injury | Date | Left or Right | Injury type | How much practice/game time was missed? | X-ray/CT/ MRI/Other? – Please list. | Surgery and/or Hospitalization – please see below | |
|---|---|---|---|---|---|---|---|
| Head/Face | | | | | | YES | NO |
| Neck | | | | | | YES | NO |
| Shoulder/Arm | | | | | | YES | NO |
| Elbow/Forearm | | | | | | YES | NO |
| Wrist/Hand | | | | | | YES | NO |
| Fingers | | | | | | YES | NO |
| Back/Spine | | | | | | YES | NO |
| Hip/Thigh | | | | | | YES | NO |
| Knee | | | | | | YES | NO |
| Leg/Ankle | | | | | | YES | NO |
| Foot | | | | | | YES | NO |
| Toe | | | | | | YES | NO |

Please describe any of the surgeries and/or hospitalizations you have had from the section above.

**Date** **Type of Surgery** **Type/Time of Hospitalization**

______________________________________________________________________________

______________________________________________________________________________

_______________________________________________

**Other Surgeries:** List below any other surgeries/hospitalizations you have had not already mentioned on this medical form.

**Date** **Type of Surgery** **Type/Time of Hospitalization**

______________________________________________________________________________

______________________________________________________________________________

_______________________________________________

**Other Information:** Have you or a family member had any other medical conditions not already on this form? Please list below the medical condition, family member, and age at death (if applicable).

________________________________________________________________________

______________________________________________________________________________

________________________________________________________________________

I, ________________________________________ (printed name) hereby recognize and verify that all above information is true and accurate to the best of my knowledge, and that I have not intentionally withheld or omitted any other information. I understand that if I am currently under the care of a physician, I must have clearance before athletic participation, and that clearance must be on file with the athletic trainer. I understand that I will not hold Emmanuel College, or any of its representatives or employees, liable for any injuries and/or illnesses not mentioned on this questionnaire.

Student-Athlete Signature ______________________________________ Date ___/___/____

Parent/Guardian Signature ______________________________________ Date ___/___/_____

**(required if athlete is under 18)**