



Concordia University

Sports Medicine

Medical History Form



Student Name: _____ **Date of Birth:** _____
Local Address: _____ **Local Phone:** _____
Home Address: _____ **Home Phone:** _____
 _____ **Social Security:** _____
Sport: _____ **Present Age:** _____
Personal Physician: _____
 In case of emergency, contact
Name: _____ **Relationship:** _____ **Phone(H)** _____ **(W)** _____

Please answer all questions. If you answer yes, please explain in the space provided:

Personal Health Questions

1. History of Anemia	Yes	No	_____
2. History of Seizures/ Convulsions	Yes	No	_____
3. History of Asthma	Yes	No	_____
4. History of Thyroid Disease	Yes	No	_____
5. History of Gastrointestinal Disease	Yes	No	_____
6. History of Rheumatic Fever	Yes	No	_____
7. History of Scarlet Fever	Yes	No	_____
8. History of Kidney Disease	Yes	No	_____
9. History of Mononucleosis	Yes	No	_____
10. History of High Blood Pressure	Yes	No	_____
11. History of Hepatitis	Yes	No	_____
12. History of Retinal Detachment	Yes	No	_____
13. History of Diabetes	Yes	No	_____
14. History of Alcohol use	Yes	No	_____
15. History of Drug use	Yes	No	_____
16. History of Arthritis	Yes	No	_____
17. History of Cancer	Yes	No	_____
18. History of Chronic Cough	Yes	No	_____
19. History of Eating Disorders	Yes	No	_____
20. History of Migraine Headaches	Yes	No	_____
21. History of Pneumonia	Yes	No	_____
22. History of Sinus Problems	Yes	No	_____
23. History of Sickle Cell Anemia or Trait	Yes	No	_____

General Medical

1. Serious illness or injury in the last year	Yes	No	What _____
2. Any known allergies to medication	Yes	No	Name _____
3. Any known seasonal allergies	Yes	No	Name _____
4. Taking any medication currently	Yes	No	Name _____
5. Have you been in the hospital	Yes	No	Why _____
6. Have you had surgery	Yes	No	When _____
7. Have you had a tetanus shot	Yes	No	Date of last Shot _____
8. Do you wear contacts for sport	Yes	No	_____
9. Do you wear glasses for sport	Yes	No	_____
10. Date of most recent menstrual period			Date _____
11. Have had emotional problems	Yes	No	_____
12. Hospitalized for emotional problems	Yes	No	_____
13. Ever passed out or fainted	Yes	No	Date _____

Orthopedic Injuries

- | | | | |
|------------------------------------|-----|----|-------------|
| 1. Have had a concussion | Yes | No | Date _____ |
| 2. Have had more than 1 concussion | Yes | No | Dates _____ |
| 3. Have had a neck injury | Yes | No | Date _____ |
| 4. Have had a shoulder dislocation | Yes | No | Date _____ |
| 5. Have had a shoulder separation | Yes | No | Date _____ |
| 6. Have had an elbow fracture | Yes | No | Date _____ |
| 7. Have had an elbow sprain | Yes | No | Date _____ |
| 8. Have had hand & finger problems | Yes | No | Date _____ |
| 9. Have had back pain | Yes | No | Date _____ |
| 10. Have had hip & groin injuries | Yes | No | Date _____ |
| 11. Have had knee injuries | Yes | No | Date _____ |
| 12. Have had knee surgery | Yes | No | Date _____ |
| 13. Have had ankle problems | Yes | No | Date _____ |
| 14. Have had foot or toes injuries | Yes | No | Date _____ |
| 15. Have had hamstring strain | Yes | No | Date _____ |
| 16. Have had quadriceps strain | Yes | No | Date _____ |

Family History

List any relative (mother, father, sister, brother, and/or grandparent) which have the following diseases:

- | | | | |
|-------------------------------|-----|----|---------------|
| 1. Cancer | Yes | No | explain _____ |
| 2. Diabetes | Yes | No | explain _____ |
| 3. Seizures or Epilepsy | Yes | No | explain _____ |
| 4. Asthma | Yes | No | explain _____ |
| 5. Tuberculosis | Yes | No | explain _____ |
| 6. Migraine Headaches | Yes | No | explain _____ |
| 7. High Blood Pressure | Yes | No | explain _____ |
| 8. Thyroid Disease | Yes | No | explain _____ |
| 9. Sickle Cell Trait | Yes | No | explain _____ |
| 10. Heart Disease | Yes | No | explain _____ |
| 11. Kidney Disease | Yes | No | explain _____ |
| 12. Stomach Problems | Yes | No | explain _____ |
| 13. Early Death (<35 yrs old) | Yes | No | explain _____ |
| 14. Early Death (<55 yrs old) | Yes | No | explain _____ |

I hereby certify that the above information is correct to the best of my knowledge:

Student Athlete Signature: _____ **Date:** _____

Parent or Guardian Signature (if athlete is a minor): _____