MIDLAND COLLEGE
ATHLETIC DEPARTMENT
MEDICAL HISTORY/QUESTIONNAIRE

PLEASE PRINT ALL INFORMATION

Name:_____ Date of Birth_____/_____/_____ Age:_____

Home Address:_____
Street or Box # City State Zip

School Address:_____SS#_____

_____

LIST ANY DRUGS THAT YOU ARE ALLERGIC TO:
DO NOT LEAVE THIS AREA BLANK!!! (if none write in NONE)

PERSONAL MEDICAL HISTORY

(PLEASE CHECK ñYESò IF YOU HAVE OR HAVE EVER HAD ANY OF THE CONDITIONS LISTED)

	YES	NO		YES	NO
High Blood Pressure	____	____	Frequent Headaches	___	____
Migraine Headaches	____	____	Frequent Sore Throat	___	____
Mononucleosis	____	____	Hearing Problems	____	____
Heart Problems	____	____	Ulcers	____	____
Heart Murmur	____	____	Appendicitis	____	____
Nervous Stomach	____	____	Hemorrhoids	____	____
Frequent Diarrhea	____	____	Kidney (infections)	____	____
Hernia	____	____	Epilepsy	____	____
Diabetes	____	____	Bladder (infections)	____	____
Pneumonia	____	____	Upper Respiratory	____	____
Hepatitis	____	____	Skin Infections	____	____
Fainting Spells	____	____	Dizzy Episodes	____	____
Heat Exhaustion	____	____	Chest Pains	____	____
Back Pain	____	____	Joint Pain	____	____
Vision Problems	____	____	Asthma	____	____

FAMILY MEDICAL HISTORY

(PLEASE CHECK ñYESò IF ANYONE IN YOUR FAMILY HAS EVER HAD ANY OF THE FOLLOWING CONDITIONS)

	YES	NO	
Diabetes	___	___	Who:_____
High Blood Pressure	___	___	Who:_____
Heart Disease	___	___	Who:_____
Fainting Spells	___	___	Who:_____
Blood Diseases	___	___	Who:_____

PERSONAL INJURY HISTORY

SPRAINS (chronic)

ANKLE _____NONE _____LEFT _____RIGHT

KNEE _____NONE _____LEFT (INSIDE) _____RIGHT (INSIDE)
_____LEFT (OUTSIDE) _____RIGHT (OUTSIDE)
_____LEFT HYPEREXTENSION
_____RIGHT HYPEREXTENSION

ELBOW _____NONE _____LEFT _____RIGHT

BACK _____NONE _____UPPER _____LOWER

NECK _____YES _____NO

SHOULDER _____NONE _____LEFT _____RIGHT
A-C JOINT SEPARATION: _____LEFT _____RIGHT

DISLOCATIONS

LIST AREA AND NUMBER OF TIMES. INCLUDES LEFT OR RIGHT.

_____
_____

FRACTURES

LIST BONE(S) AND GIVE DATES. INCLUDE LEFT AND RIGHT.

_____
_____
_____

OTHERS

1. ANY CHRONIC PULLED MUSCLES? (PLEASE LIST) _____
_____

2. ANY MEDICATIONS YOU TAKE REGULARLY? (PLEASE LIST) _____
_____

3. DO YOU WEAR?	GLASSES	YES	NO	CONTACTS	YES	NO
4. DO YOU WEAR?	BRIDGES	YES	NO	FALSE TEETH	YES	NO

OPERATIONS

NAME OF OPERATION: _____ DATE: _____

DOCTOR: _____ TOWN & HOSPITAL _____

NAME OF OPERATION: _____ DATE: _____

DOCTOR: _____ TOWN & HOSPITAL _____

OTHER MEDICAL QUESTIONS

1. How many times have you been knocked out from any cause? _____
   Dates _____

2. Have you been hospitalized as a result of a head injury? Yes No

   Dates_____

3. Have you ever been told to stop or give up sports for any reason? Yes No
   Reason_____

4. Has anyone in our family died suddenly below the age of 40 years? Yes No
   If yes, who? _____

5. Have you ever had serious trouble breathing after running or exercise? Yes No
   If yes, when? _____

6. What is the sickest you have ever been?
   When?_____
   Reason:_____

7. Have you ever spent the night in the hospital? If so, why?
   _____
   _____

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THE ANSWERS I HAVE PROVIDED ABOVE ARE CORRECT TO THE BEST OF MY KNOWLEDGE.

_____
SIGNATURE

_____
DATE

Athlete's Name:_____ SS#_____

MIDLAND COLLEGE ATHLETIC DEPARTMENT
PHYSICAL EXAMINATION

(PHYSICAL EXAMINATION TO BE COMPLETED BY PHYSICIAN)

HEIGHT _____ WEIGHT_____ BP _____ VISION _____

REGION	NORMAL	ABNORMA	DESCRIPTION & COMMENTS
ENT			
LUNGS, CARDIO, CHEST			
NEURO			
SPINE			
SHOULDERS			
ELBOW/HAND			
HIPS			
KNEES			
ANKLES			

OTHER PERTINENT INFORMATION:

_____

PHYSICIANôS NAME PRINTED _____

PHYSICIANôS SIGNATURE_____

DATE _____ **PASS _____ FAIL_____**

PHYSICIANôS ADDRESS

_____PHONE_____