

**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# \_\_\_\_\_

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

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**PERSONAL MEDICAL HISTORY**

(PLEASE CHECK  YES  NO 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 "YES" 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)**

<b><u>ANKLE</u></b>	___ NONE	___ LEFT	___ RIGHT
<b><u>KNEE</u></b>	___ NONE	___ LEFT (INSIDE)	___ RIGHT (INSIDE)
		___ LEFT (OUTSIDE)	___ RIGHT (OUTSIDE)
		___ LEFT HYPEREXTENSION	
		___ RIGHT HYPEREXTENSION	
<b><u>ELBOW</u></b>	___ NONE	___ LEFT	___ RIGHT
<b><u>BACK</u></b>	___ NONE	___ UPPER	___ LOWER
<b><u>NECK</u></b>	___ YES	___ NO	
<b><u>SHOULDER</u></b>	___ 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/HAN D			
HIPS			
KNEES			
ANKLES			

**OTHER PERTINENT INFORMATION:**

PHYSICIAN'S NAME PRINTED \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_

**DATE** \_\_\_\_\_ **PASS** \_\_\_\_\_ **FAIL** \_\_\_\_\_

PHYSICIAN'S ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_