



Frank Phillips College

Sports Medicine Medical History

I. Personal Information (Please Print)

Name: _____ Date: _____

Date of Birth: _____ Social Security #: _____

Home Phone Number: (____) _____ Local Phone Number: (____) _____

Home Address: _____ Local Address: _____

Sport: _____

Primary Care Physician: _____ Phone #: (____) _____

Address: _____

II. Hospitalizations/Surgery

Y / N Are you currently under medical supervision?

If yes, explain _____

Y / N Have you ever had surgery?

Date: _____ Reason _____

Date: _____ Reason _____

Date: _____ Reason _____

Date: _____ Reason _____

Y / N Have you ever been hospitalized for a reason other than surgery?

Date: _____ Reason _____

Date: _____ Reason _____

Y / N Have you ever been advised to have surgery not yet performed?

If yes, why _____

Y / N **I give the FPC Sports Medicine Staff permission to receive the medical record for this

surgery. If yes, sign and date _____



III. Medications

Y / N Do you regularly use any prescription medication (e.g., inhaler, seizure medication, oral contraceptives)? If yes, explain _____

Y / N Do you regularly use any non-prescription medication (e.g., Advil, Sudafed)?
If yes, explain _____

Y / N Do you regularly take nutritional supplements?
If yes, describe _____

Y / N Do you use narcotics, anabolic steroids, or street drugs?
If yes, describe _____

Y / N Do you use tobacco products?
If yes, describe _____

IV. Allergies

Y / N Aspirin
Y / N Asthma
Y / N Dust, Pollen
Y / N Food (specify) _____

Y / N Insect Stings (specify) _____

Y / N Novocain
Y / N Penicillin
Y / N Sulfa Drugs
Y / N TB Tine Test
Y / N Tetanus Serum
Y / N Other Drugs (specify) _____

V. Immunizations

Y / N Flu Date: _____
Y / N Hepatitis B Date: _____
Y / N Measles Date: _____
Y / N Mumps Date: _____
Y / N Rubella Date: _____
Y / N TB Test Date: _____
Y / N Tetanus Date: _____

VI. Illnesses

GIVE DATE IF WITHIN THE PAST 3 YEARS

Y / N Chicken Pox Date: _____
Y / N Diabetes Date: _____
Y / N Headaches (frequent) Date: _____
Y / N Measles Date: _____
Y / N Mononucleosis Date: _____
Y / N Mumps Date: _____



- Y / N Pneumonia Date: _____
- Y / N Rheumatic Fever Date: _____
- Y / N Scarlet Fever Date: _____
- Y / N Stomach Disorder Date: _____
- Y / N Tuberculosis Date: _____
- Y / N Other (specify) Date: _____

VII. Cardiovascular System

- Y / N Have you ever fainted during exercise?
- Y / N Have you ever had chest pains during exercise or after exercise?
- Y / N Have you ever been told that you might have high blood pressure?
- Y / N Have you ever been told that you have a heart murmur?
- Y / N Have you ever had racing of your heart or skipped heartbeats?
- Y / N Has anyone in your family died of heart problems or a sudden death before the age of 50?

If you answered yes to any of the above questions please explain _____

VIII. Musculoskeletal System

Have you ever injured any of the following extremities that caused you to miss significant playing time (a week or more)?

- Y / N Hip Date: _____ Explain: _____
- Y / N Abdomen / Groin Date: _____ Explain: _____
- Y / N Thigh Date: _____ Explain: _____
- Y / N Knee Date: _____ Explain: _____
- Y / N Shin / Calf Date: _____ Explain: _____
- Y / N Ankle Date: _____ Explain: _____
- Y / N Foot / Toes Date: _____ Explain: _____
- Y / N Skull / Face / Nose Date: _____ Explain: _____
- Y / N Teeth / Jaw Date: _____ Explain: _____
- Y / N Neck Date: _____ Explain: _____
- Y / N Back Date: _____ Explain: _____
- Y / N Shoulder Date: _____ Explain: _____
- Y / N Upper Arm Date: _____ Explain: _____
- Y / N Elbow Date: _____ Explain: _____
- Y / N Forearm Date: _____ Explain: _____
- Y / N Wrist Date: _____ Explain: _____
- Y / N Hand / Fingers Date: _____ Explain: _____



Y / N Severe tooth or gum trouble
Y / N Skin problems (rash, acne, boils)

Do you have loss or seriously impaired function of any paired organ?

Y / N Ear
Y / N Eye
Y / N Kidney
Y / N Ovary
Y / N Testicle

Do you wear?

Y / N Contact Lens
Y / N Eyeglasses
Y / N Dental appliance
Y / N Corrective brace or support

Y / N Do you know of or believe there is any health reason that should prevent you from participation in intercollegiate athletics?

Explain: _____

I certify that the answers to the preceding questions are correct and true. I understand that passing the physical exam does not necessarily mean that I am physically qualified to engage in intercollegiate athletics, but only that the examiner did not find a medical reason to disqualify me from participation.

Name Date

MEDICAL CONSENT

Permission is hereby granted to the attending physician, FPC Sports Medicine Staff, or other medical personnel to proceed with medical, or, minor surgical treatment, X-ray examination, and immunizations. In the event of serious injury or illness, I understand that an attempt will be made by the appropriate medical personnel to contact my parents or legal guardian. If medical personnel are not able to communicate with the responsible party the treatment necessary for my health will be provided.

Student Athlete's Signature Date

Parent/Guardian Signature Date