NORTH CENTRAL COLLEGE ATHLETIC TRAINING
MEDICAL HISTORY

Name: _____ **Date of Birth:**_____

Sport(s):_____

Instructions: When reply is yes, give date of injury and treatment. Please indicate the anatomical site of injury, left or right, and any other information you consider important. Circle the appropriate response.

		GENERAL MEDICAL
Yes	No	Have you ever been advised by a medical doctor not to participate in sports? ***For what reason?***
Yes	No	Have you had any surgeries in the past two years? ***If yes, identify the anatomical site, surgery, and date.***
Yes	No	Are you currently on prescribed medications? ***If yes, please indicate name of the medication and reason it is prescribed.***
Yes	No	Do you have any known allergies? ***Please list.***
Yes	No	Are you allergic to any medications? (i.e. aspirin, sulfa, etc.) ***If yes, please indicate name of the medication.***
Yes	No	Are you currently taking any medications? ***Please list.***
Yes	No	Do you take any supplements? ***Please list.***
Yes	No	Have you ever had heat exhaustion, heat stroke, or hyperventilation? ***If yes, please indicate which type of heat illness and when it occurred.***
Yes	No	Have you ever had an organ removed? ***If yes, which organ?***
Yes	No	Have you been told you have a hernia? ***If yes, was it repaired?***
Yes	No	Are you currently under the care of a physician? ***If yes, for what injury/medical condition?***
		HEAD AND NECK INJURIES
Yes	No	Have you ever been "knocked out", dazed or experienced a concussion during the past four years? ***If yes, please give dates.*** If answer to above is yes, did a physician have you stay overnight in a hospital? ***Please list dates and details.***
Yes	No	Have you ever had a serious neck injury? ***Please list injury and dates of injury.***
		EYE AND DENTAL
Yes	No	Do you have any eye problems? ***Please describe.***

Yes	No	Do you wear eye glasses and/or contact lenses? ***If yes, do you wear them for athletics?***
Yes	No	Do you wear dentures? ***If yes, underscore appropriate denture:*** Permanent bridge, Permanent crown of jacket, Removable partial or Full plate.
		BONE AND JOINT
Yes	No	Have you had a fracture in the past four years? ***If answer is yes, indicate the site of fracture and date.***
Yes	No	Have you ever had a shoulder injury? ***If yes, what and when was the injury?***
Yes	No	Have you ever been advised to have a surgery to correct a shoulder condition? ***If yes, what was the surgical repair and when was the surgery completed?***
Yes	No	Have you ever experienced a severe sprain, dislocation or fracture? ***If yes, give date and amount of limitation?***
Yes	No	Have you ever had an injury to your back? ***If yes, give the date and nature of the injury?*** If yes, did you seek the advice or care of a physician? What was the therapy and is it completed?
Yes	No	Do you experience back pain? ***If yes, please indicate frequency with which you experience pain by underscoring the following: very seldom, frequently, only with exercise.***
Yes	No	Have you ever been told that you injured the ligaments of either knee? ***Please give dates.***
Yes	No	Have you ever been advised to have surgery to a knee to correct a condition? ***Please give dates.***
Yes	No	Have you ever experienced a severe sprain of either ankle during the past four years? ***Please give dates.***
Yes	No	Do you have a pin, screw, or plate somewhere in your body as a result of bone or joint surgery? ***If yes, indicate anatomical site and date of surgery.***
Yes	No	Do you have limited movement in any of your joints? ***Please explain.***
Yes	No	Have you ever been told you have torn muscle/s? ***Please explain.***
		DISEASE AND ILLNESS
Yes	No	Have you been diagnosed with ADHD? Are you currently on medication for ADHD? ***If yes, which medication?***
Yes	No	Have you ever experienced a seizure or been informed that you might have a seizure disorder? ***If yes, please provide the date/s.***
Yes	No	Have you had hepatitis during the past three years?
Yes	No	Have you been treated for infectious mononucleosis, pneumonia, or any other infectious diseases during the past 12 months? ***If yes, please provide the date/s of illness.***
Yes	No	Have you ever been treated for diabetes? ***If yes, please provide your current management plan.***
Yes	No	Have you ever been treated or informed by a physician that you have had rheumatic fever?
Yes	No	Have you ever been told you have a heart murmur, mitral valve prolapse or increased systemic blood pressure? Please circle. ***Please explain any treatment for the condition.***

Yes	No	Have you had any illness requiring bed rest of one week or longer during the past year? ***Please give date and explain.***
Yes	No	Do you have asthma?
Yes	No	Do you use an inhaler or rescue inhaler? ***If yes, please list the name of the medication.***
Yes	No	Have you ever fainted during exercise? ***Please explain.***
Yes	No	Have you ever experienced chest pain or discomfort during exercise?
Yes	No	Have you ever experienced excessive, unexpected, and unexplained shortness of breath or fatigue associated with exercise?
Yes	No	Do you have a family history of premature death (sudden or otherwise), or significant disability from cardiovascular disease in close relatives younger than 50 years old? ***If yes, which family members?***
Yes	No	Do you have a family history of the occurrence of the following conditions: Hypertrophic cardiomyopathy, dilated cardiomyopathy, long QT syndrome, Marfan Syndrome, clinically important arrhythmias? ***If yes, which family members?***
Yes	No	Have you received a tetanus shot in the last 10 years? ***If yes, please provide the date.***
		FEMALE ATHLETES
Yes	No	How old were you when your menstrual period started?
Yes	No	Is your menstrual cycle 28 days long? ***If not, please indicate length of cycle***: Please give approximate length of your monthly menstrual period.
Yes	No	Do you have menstrual cramps which are severe enough to require medication?
Yes	No	Do you take birth control medications? ***If yes, which medication?***
		Additional Medical History Write in medical problems, injuries, or conditions that you have had and are not included in the previous questionnaire. Please use additional sheet(s) if necessary.

I, the undersigned, hereby acknowledge, affirm and represent that all above statements are true and accurate to the best of my knowledge, and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past medical history, I fully understand that North Central College disclaims liability, and will not be held liable for any injuries and/or illness not noted.

_____ _____

Student-Athlete Signature **Date**

NORTH CENTRAL COLLEGE ATHLETIC TRAINING
PHYSICAL EXAMINATION FOR PARTICIPATION IN ATHLETICS

*****This form must be completed and signed by a M.D. or D.O. only*****

Last Name _____First Name _____M ____ Sex M F

Sport/s in which you plan to participate: _____

Date of Birth_____ Age_____

Height_____ inches Weight_____lbs

B/P _____/_____ Pulse _____Resp _____ Vision R: 20/_____ L: 20/_____ Glasses Yes No Contacts Yes No

Urinalysis: Sugar _____ Protein_____ Blood _____ Other _____

MEDICAL SCREENINGS: Please explain any abnormal findings to the right

NORMAL	ABNORMAL	GENERAL
		Eyes: Vision
		Ears: Hearing, Canals, Drums
		Nose: Septum, Obstructions
		Mouth: Membranes, Throat, Tonsils, Teeth
		Chest: Lungs
		Heart:
		Abdomen/Pelvis: Viscera Scars, Hernia
		MUSCULOSKELETAL
		Spine:
		Shoulders:
		Wrist/Hands:
		Hips/Thighs:
		Knees:
		Ankles:
		Feet:

Additional Comments: _____
_____

ATHLETIC PARTICIPATION: Please Circle Below

Approved Without Limitation

Approved With Limitation Specify _____
_____

Not Approved Specify _____
_____

Physician Signature **(MD/DO ONLY)** _____

Print Last Name _____

Physician's Address _____
Date of Exam_____ **Must be completed on or after June 1, 2016**