

SPORT(S) _____
DATE _____

**ATHLETIC MEDICAL HISTORY
SAGINAW VALLEY STATE UNIVERSITY**

NAME _____ YEAR IN SCHOOL: 1 2 3 4 5
LAST FIRST MIDDLE

S.S # _____ - _____ - _____ DATE OF BIRTH _____ SEX MALE FEMALE

HOME ADDRESS _____
Number & Street City State Zip

HOME PHONE (____) _____ CELL PHONE (____) _____

COLLEGE ADDRESS _____
Number & Street City State Zip

FAMILY DOCTOR _____ PHONE NUMBER (____) _____

PERSON TO NOTIFY IN CASE OF EMERGENCY _____
Name Relationship

PHONE NUMBER (____) _____ BUSINESS/CELL PHONE (____) _____

PLEASE BE SPECIFIC WHEN ANSWERING THE FOLLOWING QUESTIONS. IF "YES" IS INDICATED, PLEASE EXPLAIN.

Date last seen by a doctor: _____

List the condition(s) that the doctor was seen for (please be specific): _____

List any injuries, accident(s), or operations and dates: **(Please note: The SVSU Medical Staff requires a copy of the surgical report for any surgeries you have had. This information can be obtained from the physician who provided your care).**

Are you currently under the care of a physician? YES / NO If yes, please explain _____

***Please note: If you are currently under the care of a physician for an injury or illness, a detailed clearance note from your physician is needed in order for you to be able to participate in your sport. If performance needs to be limited please have your physician include what activities you are allowed to do.**

Medical History

If you answer **YES** to any questions, please give an explanation with dates of injury or illness.

Cardiac History

Have you ever passed out during or after exercise? YES / NO _____

Have you ever become ill from exercising in the heat? YES / NO _____

Have you ever been dizzy during or after exercise? YES / NO _____

Have you ever had chest pain during or after exercise? YES / NO _____

Have you ever had unexplained racing of your heart or skipped heartbeats? If yes, how often? YES / NO _____

Have you ever had high blood pressure or high cholesterol? YES / NO _____

Have you ever been told that you might have a heart murmur? YES / NO _____

Have you ever been diagnosed with Marfan's Syndrome? YES / NO _____

Has any physician ever denied or restricted your participation in sports for any heart problems? YES / NO _____

Respiratory History

Do you cough, wheeze, or have trouble breathing during or after activity? YES / NO _____

Do you have asthma? If yes, please list the medication that you are taking. YES / NO _____

Do you have seasonal allergies that require medical treatment? YES / NO _____

If you are under medical treatment for allergies please list the medications you are currently taking. _____

Illnesses/Infections

Have you ever had a severe viral infection (Mononucleosis)? YES / NO _____

Do you have any current skin problems (itching, rashes, acne, warts, fungus, or blisters)? YES / NO _____

Have you or anyone in your immediate family ever had tuberculosis? YES / NO _____

Have you ever had a seizure? YES / NO _____

Abdominal Injuries/Illnesses

Have you ever been found to have only one organ of usually paired organs (one kidney, testicle, etc)? YES / NO _____

Have you ever been diagnosed with a hernia? YES / NO _____

Have you ever had an Ulcer? YES / NO _____

Head/Neck/Facial Injuries

Have you ever had a head/neck injury or concussion? If yes, how many? YES / NO _____

Have you ever been knocked out, become unconscious, or lost your memory? If yes, how long did this last YES / NO _____

Do you have frequent or severe headaches? If yes, how often YES / NO _____

Have you ever had numbness or tingling in your arms, hands, legs, or feet? YES / NO _____

Have you ever had a stinger, pinched nerve, or burned? YES / NO _____

Have you had any problems with your eyes or vision? YES / NO _____

Do you wear glasses, contacts, or protective eyewear? YES / NO _____

Have you ever had a fracture of the face, head, or neck? YES / NO _____

Have you ever had surgery on your face, head, or neck? YES / NO _____

Back Injuries

Have you ever experienced lower back pain or any other back injury? YES / NO _____

Have a history or disc problems or pinched nerve? YES / NO _____

Have you ever had a fracture of your back? YES / NO _____

Have you ever had surgery on your back? YES / NO _____

Knee/Lower Leg Injuries

Have you ever experienced a knee ligament sprain? YES / NO _____

Have you ever experienced a cartilage injury? YES / NO _____

Have you ever experienced a meniscal injury? YES / NO _____

Have you ever experienced a patella injury? YES / NO _____

Have you ever suffered from knee tendinitis? YES / NO _____

Do you have a history or knee surgery? YES / NO _____

Do you have a history of shin splints? YES / NO _____

Have you ever been diagnosed with compartment syndrome? YES / NO _____

Ankle/Foot Pain Injuries

Have you ever experienced an ankle sprain? YES / NO _____

Have you ever experienced a fracture of your ankle or foot? YES / NO _____

Do you have any history of stress fractures in your ankle or foot? YES / NO _____

Have you ever had surgery on your ankle or foot? YES / NO _____

Shoulder Injuries

Have you ever experienced a shoulder dislocation? YES / NO _____

Have you ever experienced a shoulder subluxation? YES / NO _____

Have you ever experienced a shoulder separation? YES / NO _____

Have you ever experienced shoulder impingement? YES / NO _____

Do you have a history of tendinitis? YES / NO _____

Have you ever had surgery on your shoulder? YES / NO _____

Elbow /Wrist Injuries

Have you ever had an elbow/wrist dislocation? YES / NO _____

Have you ever had an elbow/wrist fracture? YES / NO _____

Have you ever had elbow/wrist tendinitis? YES / NO _____

Have you ever suffered an elbow/wrist sprain? YES / NO _____

Have you ever had surgery on your elbow or wrist? YES / NO _____

Protective Devices

Do you use any special protective or corrective equipment or devices that are not usually used for your sport or position (knee brace, special neck collar, foot orthotic, retainer on your teeth, hearing aid, etc.)? YES / NO _____

General Medical Conditions

Have you ever been diagnosed with any of the following medical conditions:

Sickle Cell Anemia/ Sickle Cell Trait- YES / NO _____

Rhabdomyolysis- YES / NO _____

Diabetes- YES / NO _____

ADHD- YES / NO _____

Seizure- YES / NO _____

Family History

Has anyone in your immediate family under the age of 35 died suddenly? YES / NO _____

Does anyone in your immediate family have:

Diabetes (High Blood Sugar): YES / NO Relationship? _____

Allergies (Hay Fever, Asthma): YES / NO Relationship? _____

Migraine Headaches: YES / NO Relationship? _____

Heart Disease or High Blood Pressure: YES / NO Relationship? _____

Marfan's Syndrome (Abe Lincoln's Disease): YES / NO Relationship? _____

Reproductive History

MALES

Do you currently have two functioning testicles? YES / NO If no, explain: _____

FEMALES

When was your first menstrual period? _____

When was your most recent menstrual period? _____

How much time do you usually have from start of one period to the start of another? _____

Have you ever had painful, irregular, or abnormal periods in the last year? YES / NO _____

Do you want to weigh more or less than you do now? YES / NO _____

Medical Testing

Have you had any of the following diagnostic tests taken? If **YES**, explain and give dates.

MRI- YES / NO _____

CAT SCAN- YES / NO _____

ECHO- YES / NO _____

BONE SCAN- YES / NO _____

X-RAY- YES / NO _____

Due to an injury have you missed any games/practices in the last 3 years? YES / NO _____

Have you been hospitalized in the last 3 years? YES / NO _____

ANY MEDICAL INFORMATION WITHHELD, INCOMPLETE OR INCORRECT MAY RELIEVE SAGINAW VALLEY STATE UNIVERSITY FROM ALL MEDICAL/LEGAL LIABILITY AND MAY DISQUALIFY YOU FROM PARTICIPATION ON ANY SAGINAW VALLEY STATE UNIVERSITY ATHLETIC TEAM.

I HAVE READ AND UNDERSTOOD THE ABOVE STATEMENT AND THE ABOVE QUESTIONS HAVE BEEN ANSWERED COMPLETELY AND TRUTHFULLY TO THE BEST OF MY KNOWLEDGE.

Athlete's Signature

Date

Parent/Guardian Signature

Date