

**HANOVER COLLEGE SPORTS MEDICINE
MEDICAL INFORMATION FORM**

Last Name _____	First Name _____	
SSN _____	Grade (circle) Fresh Soph Jun Sen	
Date of Birth _____	Sex (circle) M F	
Sport 1 _____	Sport 2 _____	Sport 3 _____
Home Address _____	Campus Address _____	
City, State, Zip _____	City, State, Zip _____	
Home Phone _____	Campus Phone _____	
Cell Phone _____	Email _____	

EMERGENCY CONTACTS

Primary Name _____	Secondary Name _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Home Phone _____	Home Phone _____
Work Phone _____	Work Phone _____
Cell Phone _____	Cell Phone _____
Email _____	Email _____
Relationship _____	Relationship _____

STAFF USE ONLY:

Height: _____ Weight: _____ BP: _____ Pulse: _____

Contacts: Yes _____ No _____ Vision: Right _____ Left _____

RIGHT LEG:

Hamstrings Pass Fail

Quads Pass Fail

LEFT LEG:

Hamstrings Pass Fail

Quads Pass Fail

MEDICAL HISTORY

Do you now or have you had in the past, problems with the following:

	Yes	No		Yes	No		Yes	No
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Change	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
German Measles	<input type="checkbox"/>	<input type="checkbox"/>	Cyst	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	GI Tract Trouble	<input type="checkbox"/>	<input type="checkbox"/>	High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Tooth/Gum Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Ear Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Heat Illness	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Nose Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Allergy To Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Throat Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Allergy To Sulfamides	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Allergy To Serum	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Headache	<input type="checkbox"/>	<input type="checkbox"/>	Allergy To Food	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Colds	<input type="checkbox"/>	<input type="checkbox"/>	Allergy To Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Allergy To Insect Stings	<input type="checkbox"/>	<input type="checkbox"/>
						Allergy To Latex	<input type="checkbox"/>	<input type="checkbox"/>

Females: Do you have...

	Yes	No
Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>
Severe Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Flow	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>
Amenorrhea	<input type="checkbox"/>	<input type="checkbox"/>

Primary Care Physician:

Name _____

Phone _____

City _____

Has any person in your family died before the age of 40? Yes No

Relationship	Cause of Death
Mother	_____
Father	_____
Brother	_____
Sister	_____
Grandparents	_____

Please List Medications Below
(include daily over-the-counter and prescriptions)

Answer all of the following questions concerning your medical history. Please include the name of your treating physician (if known), the date of injury, the specifics of the injury (what was injured/diagnosis), and any other pertinent information (surgery, pins or screws, current restrictions, hospitalizations, etc.)

Have you ever had a **head** injury? (bell rung, concussion, etc) Yes No

Diagnosis _____

When _____

Doctor _____

Comments _____

Have you ever had a **neck** injury? (fracture, burn, etc) Yes No

Diagnosis _____

When _____

Doctor _____

Comments _____

Have you ever had a moderate or severe **foot or ankle** injury? Yes No

Diagnosis _____

When _____

Doctor _____

Comments _____

Have you ever had a moderate or severe **knee** injury? Yes No

Diagnosis _____

When _____

Doctor _____

Comments _____

Have you ever had a moderate or severe **thigh or hip** injury? Yes No

Diagnosis _____

When _____

Doctor _____

Comments _____

Have you ever had a moderate or severe **low back or trunk** injury? Yes No

Diagnosis _____

When _____

Doctor _____

Comments _____

Have you ever had a moderate or severe **shoulder** injury? Yes No

Diagnosis _____

When _____

Doctor _____

Comments _____

Have you ever had a moderate or severe **elbow or wrist** injury? Yes No
 Diagnosis _____
 When _____
 Doctor _____
 Comments _____

Have you ever had a moderate or severe **hand or finger** injury? Yes No
 Diagnosis _____
 When _____
 Doctor _____
 Comments _____

Have you ever had any other hospitalizations or surgery for other reasons? If yes, please explain: Yes No

Do you currently wear any type of braces or specialized equipment to protect or prevent an injury? Yes No
 (knee brace, orthotics, padding, etc) If yes, please explain:

List any other information concerning your medical history that the Sports Medicine staff should be aware of:

I verify by my signature below, that the information given is complete and accurate to the best of my knowledge. If the above information changes, I am responsible for updating my medical file by contacting the Head Athletic Trainer or Team Physician.

 Student Signature

 Date

 Parent/Guardian Signature (If Student is Under the Age of 18)

 Date