

Central State University

Medical and Family History Form

Name _____ Sport _____

Social Security Number _____ - _____ - _____ Date of Birth _____

HEALTH HISTORY (Please answer the following questions)

YES	NO	QUESTIONS	YES	NO	QUESTIONS
		Chronic or Recurrent Illness?			Hearing: Ringing or Motion Sickness?
		Illness lasting over 1 week?			Weight: Sudden changes or special diet?
		Missing Organs (Eye, Kidney, Testicle)?			Injuries requiring doctor treatment?
		Problems with Heart or Blood Pressure?			Neck Injury: (Chronic or Acute)
		Chest Pain with Exercise or Heart Murmur?			Back Injury: (Chronic or Acute)
		Dizziness or Fainting during Exercise?			Ankle Injury: (Chronic or Acute)
		Dizziness, Headaches, Fainting, etc?			Shoulder Injury: (Chronic or Acute)
		Heat Exhaustion, Heat Stroke, or Heat related problems?			Any Surgeries?
		Irregularities in Bowel or Urinary habits?			Other joint injuries?
		Bruise easily or nose bleeds?			Broken Bones?
		Asthma or allergies? Breathing Irregularities?			Has any family member died suddenly at less than 40yrs of age?
		Returning athletes: please list new injuries!			Last Tetanus Shot ___ / ___ / ___

Use the space below to explain or provide additional information to any of the questions marked **YES**.

FAMILY HISTORY

Please place the family member(s) below, who suffer or have suffered from the following:

Ex: Heart Trouble-Gr.Father, Gr.Mother, Father, Mother, Sister, Brother, Self

Asthma / Allergies _____

Anemia / Sickle Cell or Trait _____

Diabetes / Gout _____

Cancer / Tumor _____

Epilepsy _____

Yellow Jaundice _____

High Blood Pressure _____

Kidney or Bladder Trouble _____

Ulcer _____

Arthritis _____

Heart Trouble _____

Rheumatic Fever _____

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EYE and DENTAL HEALTH

- 1) Do you wear eye glasses, contacts, or both? _____
If yes, during participation? _____
When was your last eye exam? _____
- 2) Do you wear any Dental Appliances? _____
If yes, What type? Permanent Bridge Crown Removable Partial Full Plate
- 3) Do you have any "Dead" or "Loose" Teeth? _____
If yes, How many and Where? _____

MAJOR HOSPITALIZATIONS

Have you ever had any major hospitalizations or surgeries? YES OR NO

Operation / Illness

Year

Please List: _____

MEDICINES

Are you currently taking any medications? Yes No

If yes, please list _____

Are you allergic to any Medications? Yes No

If yes, please list _____

FOR WOMEN ONLY

Do you have any problems during your menstrual cycle? Yes / No

If yes, what problems? _____

Are you currently taking any form of birth control? Yes / No

If yes, what kind?

Longest time you had between cycles? _____

Do you have Cysts on your Ovaries? Yes / No

If yes, have you had any complications? _____

The information that I have provided on this medical and family history form is true to the best of my knowledge.

Parent/Guardian Signature and Date

Student-Athlete Signature and Date