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LAKE FOREST COLLEGE STUDENT – ATHLETE MEDICAL HISTORY FORM

STUDENT DEMOGRAPHICS				
Name:			Year in School: Fr So Jr Sr	
Sport(s): Fall:	Winter:	Spring:		
Birth date:	Age:	Sex: M F	Social Security Number:	
Dorm:	School Box #:	School Phone #:	Home Phone:	
Parents Names:			Mother's Work Phone:	
Address:			Father's Work Phone:	
City:		State:	Zip:	
Are you currently under supervision of physician? N Y			Doctor's Phone:	
Family Physician:				
Address:				

MEDICAL HISTORY			
ALLERGIES: (Medications, Food, Environmental, Insect bites/stings)		None Known	
Allergy:	Reaction:	Allergy:	Reaction:

MEDICATIONS TAKEN ON A REGULAR BASIS		None
Medication:	Dose/Frequency:	Reason:

LIST ANY SURGERIES, ILLNESSES OR HOSPITALIZATIONS IN THE PAST YEAR					None
Medical Reason or Type of Surgery	Date	Medical Reason or Type of Surgery	Date	Medical Reason or Type of Surgery	Date

DO YOU HAVE OR HAVE YOU EVER BEEN TOLD YOU HAVE ANY OF THE FOLLOWING?					
Condition	N	Y	Condition	N	Y
1 Asthma/Exercise Induced Asthma			6 Heat Related Illness (Exhaustion, Stroke)		
2 Mononucleosis			7 Loss of/impaired-organ function (eye, kidney or testicle)		
3 Diabetes			8 Nose Bleeds		
4 Epilepsy/Seizures			9 Exposure to Tuberculosis (TB), HIV, Hepatitis		
5 Concussion/Loss of Consciousness					
FOR MEN	**N**	**Y**	**FOR WOMEN**	**N**	**Y**
10 History of hernia or hernia surgery			11 Positive pregnancy test in the last year		

LIST ANY ORTHOPEDIC INJURIES WITHIN THE PAST YEAR:							None		
Injury	**N**	**Y**	**Date**	**Comment**	**Injury**	**N**	**Y**	**Date**	**Comment**
Head					Hip				
Neck					Knee				
Back					Shin Splints				
Shoulder					Leg				
Arm/Elbow					Foot				
Hand/Wrist					Ankle				

I hereby certify that the above questions are answered to the best of my knowledge.

Signature of Student: ______________________________ **Date:** ____________________________

HEALTH CARE PROVIDER

COMMENTS BY HEALTH CARE PROVIDER (please address all positive responses)

HCP, PLEASE ASK THE FOLLOWING QUESTIONS OF THE ATHLETE:

Do you have or have you experienced:	**N**	**Y**	**Do you have or have you experienced:**	**N**	**Y**
1. Chest pain, chest discomfort or palpitations with exercise?			6. History of elevated blood pressure?		
2. Fainting spells or dizziness with exercise?			7. Family history of sudden death of someone in the family?		
3. Excessive or unexpected shortness of breath with exercise?			8. Family history of severe cardiac disease or heart condition?		
4. Excessive fatigue with exercise?			9. Family history of Marfan's disease?		
5. History of heart murmur?					

VISUAL ACUITY: \ R: 20/ ___L: 20/ ___ With: glasses/contact lenses	**Ht:**	**Wt:**	**B/P: (brachial/sitting)**	**P (precordial)**	**RESP**	**Femoral Artery Pulses** R ______________ L ______________	**Evidence of Marfan's** Yes ____ No ____

Requires basic screening only **Signature:** ______________________________ **Health Care Provider**
Requires Physical Exam **Signature:** ______________________________ **Health Care Provider**

Signature of Lake Forest College Medical Reviewer: ____

2/04