Blood Pressure ______/______ **2008 - 2009**
Height ______
Weight ______

GUILFORD COLLEGE ATHLETE'S MEDICAL FORM

Name____ SS#________-_____-________
(Last) (First) (Middle)

D.O.B._______________Sex____ Sport(s) ____

Permanent Address_____________________________Phone (_____) ________________________
(Street)

____
(City) (State) (Zip)

Local Address__________________________________Phone (_____) ______________________
(Street Address or Dorm) (Dorm Room #)

Person to be Notified in Case of Emergency:

Name____Relationship ____________________

Address ____
(Street) (City) (State) (Zip)

Phone _________________________________Cell phone________________________________

E-mail__________________________________

Parent's Information:

Father's full name ____ Living? ___Yes ___No

Mother's full name ____ Living? ___Yes ___No

Parent's address ____
(Street) (City) (State) (Zip)

Phone(H)________________Father(W)________________Mother(W) ______________________

Cell Phone - Father_______________________________Mother ___________________________

E-mail - Father______________________________Mother _______________________________

If you have an HMO or PPO Primary Insurance Policy, list the name of your preferred Provider, phone number and address:

Physician Name ____

Physician Address ____

Physician Phone ____

PRE-PARTICIPATION EVALUATION HISTORY

Cardiovascular

1. Has anyone in your family died suddenly of heart problems before age 50? ___Y ___N
2. Have you ever been dizzy or passed out during or after exercise? ___Y ___N
3. Have you ever been told you have a murmur? ___Y ___N
4. Does your heart skip a beat or beat too fast at times? ___Y ___N
5. Do you have chest pains during or after exercise? ___Y ___N
6. Have you ever had seizures? ___Y ___N
7. Have you had a severe viral infection or other infection in the past month? ___Y ___N
8. Have you ever been told by a doctor that you have had pericarditis, myocarditis or endocarditis? ___Y ___N
9. Has any family member suffered a heart attack or any other heart conditions? ___Y ___N

Comments:

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Neurological

1. Have you had any “bell ringers” or concussions (been knocked out) in the past? ___Y ___N
2. Have you had any in the past year? ___Y ___N
3. How many concussions have you had? ____________
4. What is the longest amount of time you have been unconscious? ____________
5. Did you have symptoms of headache or concentration difficulties after head injury? ___Y ___N
6. Do you have frequent headaches? Migraines? ___Y ___N
7. Are they associated with sports activities? Weight lifting? ___Y ___N
8. Have you ever had seizures? ___Y ___N
9. Have you ever had a stinger, a burner, or pinched nerve? ___Y ___N
10. Have you had recurrent symptoms or persistent numbness following a stinger? ___Y ___N
11. Have you had any other neck injuries? ___Y ___N

Comments:

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Musculoskeletal

1. Have you had any knee injuries? ___Y ___N
2. Did this require surgery? ___Y ___N
3. Do your knees swell, lock or give way? ___Y ___N
4. Have you had ankle sprains? How many? How were these treated? ___Y ___N

   ____

5. Do your ankles feel weak or sprain easily? ___Y ___N
6. Have you had any serious shoulder problems or a dislocation? ___Y ___N
7. How were these treated? ______________________________
8. Have you had any other joint injuries? Dislocations? ___Y ___N
9. Have you ever had any fractures? ___Y ___N
10. Do you have any back problems? ___Y ___N

Comments:

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Respiratory

1. Do you have any trouble with shortness of breath with exercise? ___Y ___N
2. Do you have recurrent cough with exercise? ___Y ___N
3. Any history of seasonal allergies, allergic rhinitis, wheezing with infections (other times) ? ___Y ___N
4. Do you use or have you used any inhalant medications? ___Y ___N
5. Do you ever have hives or intense itching with exercise? ___Y ___N
6. Do you have asthma or exercise-induced asthma? ___Y ___N
7. Have you ever had a collapsed lung? ___Y ___N

Comments:

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___

General Medical

1. Do you or any family members have diabetes? ___Y ___N
2. Do you have any chronic skin conditions? ___Y ___N
3. Do you have any visual problems or use glasses or contacts? ___Y ___N
4. Do you have dentures? ___Y ___N
5. Have you lost any paired organ – e.g., kidney, eye, testicle? ___Y ___N
6. Do you have any other active medical problems? ___Y ___N
7. Do you take any regular medications? ___Y ___N

Comments:

___

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Heat Illness

1. Do you have severe cramps in hot weather? ___Y ___N
2. Have you ever fainted in the heat? ___Y ___N
3. Have you ever had heat stroke or required IV therapy after exposure to heat? ___Y ___N
4. Have you ever fainted or passed out? ___Y ___N

Comments:

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___

Medication Use

1. What medicines do you regularly take? ____________________
2. Do you use over-the-counter pain medicines (e.g., Advil, Aleve,Tylenol)? ___Y ___N
3. Are you taking vitamins, herbs or supplements? ___Y ___N
4. Have you ever used anabolic steroids? ___Y ___N
5. Do you smoke or use any form of tobacco? ___Y ___N
6. How much alcohol do you drink? ____________________
7. Do you use any illegal drugs? ___Y ___N
8. Do you have an allergy to any drugs? If yes, please list. ___Y ___N
   ____
9. **FEMALES ONLY**: Are you currently taking any female hormones (estrogen, progesterone, birth control pills) for the purpose of regulating your periods? ___Y ___N

Comments:

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____
____

Miscellaneous

1. Do you have any personal or other health questions you would like to discuss with the doctor? ___Y ___N
2. Have you ever had a bout(s) with epilepsy? ___Y ___N
3. Have you ever consulted a physician for ulcers, or a disease of the stomach, intestine, liver or gall bladder? ___Y ___N
4. Have you ever had a hernia or disease of the muscle or skin? ___Y ___N
5. Have you ever had any form of cancer, tumor or growth of any kind? ___Y ___N
6. Were you born with two normal
   - EYES ___Y ___N
   - EARS ___Y ___N
   - KIDNEYS ___Y ___N
7. Do you wear glasses or contact lenses? ___Y ___N
8. Are you legally blind in either eye? ___Y ___N
9. Have you ever been diagnosed with an eating disorder? ___Y ___N

MEN ONLY:

10. Were you born with two normal testes? ___Y ___N
11. Have you ever had surgery to remove or repair a testicle? ___Y ___N

Comments:

____
____
____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Athlete's Signature____________________ Date ____________

Form Reviewed By____ Date __________________

MEDICAL EXAMINATION for (name of student) __________________________________

Sport____New Athlete______ Returning Athlete______

	OK	Problem	Comment
Concussions	____	_______	____
Eyes	____	_______	____
Ears, nose, throat	____	_______	____
Head and neck	____	_______	____
Shoulder	____	_______	____
Skin and scalp	____	_______	____
Lymphatics	____	_______	____
Thorax	____	_______	____
Lungs	____	_______	____
Heart	____	_______	____
Abdomen	____	_______	____
Hernia	____	_______	____
Genitalia	____	_______	____
Neurologic	____	_______	____
Elbows, hands, wrists	____	_______	____
Back	____	_______	____
Knees	____	_______	____
Ankles	____	_______	____
Feet	____	_______	____

Physician Evaluation

_____ No athletic participation

_____ Limited athletic participation

_____ Clearance withheld until ____

_____ Full, unlimited athletic participation

Physician's Signature____Date ___________________