

VALDOSTA STATE UNIVERSITY INITIAL MEDICAL HISTORY FORM

PERSONAL/EMERGENCY CONTACT INFORMATION	
NAME: _____ <div style="display: flex; justify-content: space-around; font-size: small;"> LAST FIRST MIDDLE </div>	SPORT(S): _____
VSU Student ID#: _____	Date of Birth: ___/___/___
Local Phone: _____	Cell Phone: _____
VSU Email: _____@valdosta.edu	Other Email: _____
Emergency Contact: phone _____/email _____ Relation: _____	
Emergency Contact: _____/email _____ Relation: _____	

MEDICAL HISTORY INFORMATION			
	YES	NO	COMMENT/EXPLANATION
1. Have you ever been disqualified or restricted from athletic participation for any reason? (game/practice/season)			
2. Are you missing a kidney, eye, testicle or any other organ?			
3. Have you had a medical illness/injury since your last check-up by a physician?			
4. Do you have an ongoing/chronic illness?			
5. Have you had mononucleosis in the past few months?			
6. Have you had a severe viral infection within last month			
7. Have you ever been hospitalized overnight or had surgery?			
8. Have you ever had a sprain, strain, stress fracture?			Identify bone/joint?
9. Have you ever broken a bone or dislocated a joint?			
10. Have you ever had an x-ray, MRI, CT Scan, or injections?			
11. Have you ever gone to physical therapy or seen an athletic trainer for an injury?			
12. Do you use special protective or corrective equipment not typically used for your sport or position?			Bracing, hearing aid, retainer, etc.:
13. Have you ever had a stinger?			
14. Have you ever had numbness or tingling in your extremities?			
15. Have you ever had an x-ray on your neck?			
16. Have you ever been diagnosed with a heart murmur?			
17. Has a doctor ever ordered tests for your heart?			

	YES	NO	COMMENT/EXPLANATION
18. Has a physician ever diagnosed you with high blood pressure or high cholesterol?			
19. Has a member of your immediate family ever died unexpectedly or before the age of 50?			
20. Do you cough, wheeze, or have trouble breathing during exercise?			
21. Do you get dizzy or pass out during or after exercise?			
22. Do you get tired more quickly than others during exercise?			
23. Have you ever had chest pain or pressure during or after exercise?			
24. Does your heart ever race or skip beats?			
25. Have you or anyone in your family been diagnosed with Marfan's Syndrome?			
26. Have you ever had a head injury/concussion?			
27. Have you ever had a head injury with loss of consciousness?			
28. Have you ever had a head injury with confusion or memory loss?			
29. Have you ever had problems with heat illness?			
30. Do you ever get cramps when exercising in the heat?			
31. Have you or someone in your family been diagnosed with sickle cell trait or sickle cell anemia?			
32. Have you ever been had a seizure or been diagnosed with epilepsy?			
33. Do you have allergies?			
39. Have you or anyone in your family been diagnosed with asthma?			
40. Have you or anyone in your family been diagnosed with diabetes?			
40. Do you have eye or sight problems?			Do you wear <input type="checkbox"/> contacts <input type="checkbox"/> glasses <input type="checkbox"/> protective eyewear/goggles?
41. Do you want to lose weight?			
42. Do you want to gain weight?			
43. Loss of weight to meet weight requirement of sport			
44. Do you limit or carefully control what you eat?			
45. Feelings of being stressed out			
46. Have you had any recent skin infections?			
47. List any MEDICATIONS (prescription, over-the-counter, vitamins, supplements, etc.) that you are presently taking and the prescription information:			
Name of Medication	Dosage	Directions	

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

Signature of Athlete _____
Date _____

Signature of Parent/Guardian _____
Date _____