



Intercollegiate Sports Medical History

Questions?
440-775-8514

Return to:
Director of Sports Medicine
Department of Athletics and
Physical Education
200 Woodland St.
Oberlin, OH 44074

► Only for students interested in athletics

Please print or type.

DEADLINE: July 1, 2009

Or fax to: 440-775-8616

The information you provide on this form is strictly for the use of the Sports Medicine Department and will not be released to anyone without your knowledge and consent. You must submit additional copies of the following forms in this book: Medical History/Physical Exam (pages 41-43) and Insurance Information (page 47) to the Sports Medicine Department.

Name: _____ Date of Birth: _____
Last First Middle Month/Date/Year

Sport(s): _____ Age: _____ Social Security Number (if available): _____

Home Address: _____ Home Telephone: _____
Number and Street (Country/Area Code) Number

City State Zip Country

Campus Residence (if known): _____

Campus Telephone (if known): _____ Campus OCMR box (if known): _____

Have you ever _____ *If yes, please explain below.*

had surgery? Yes No _____

passed out during or after exercise? Yes No _____

been told you have a heart murmur? Yes No _____

had racing of your heart or skipped beats? Yes No _____

Has anyone in your family died of heart problems or sudden death before the age of 50? Yes No _____

Have you ever had a head injury? Yes No _____
If yes, explain, including number. _____

Have you ever been knocked unconscious? Yes No _____
If yes, explain. _____

Have you ever had a seizure? Yes No _____
If yes, explain, including number. _____

Are you currently taking any medications? Yes No _____
If yes, list medications. _____

(Please complete reverse side.)

Intercollegiate Sports Medical History *(continued)*

Have you been diagnosed with ADD or ADHD? Yes No

If yes, name of physician and treatment dates. _____

If you answered yes, do you take medication for ADD/ADHD? Yes No

If yes, specify medication. _____

If you have a history of allergies, do you require the use of emergency medication? Yes No

If yes, specify medication. _____

If you have a history of asthma, do you require the use of emergency medication? Yes No

If yes, specify medication. _____

If you have a history of diabetes, do you require the use of medication? Yes No

If yes, specify type and form of medication. _____

Females only: Do you have a history of menstrual irregularities? Yes No

If yes, describe. _____

Date of last tetanus shot: ____/____/____
mo. day year

Have you ever sprained, strained, dislocated, fractured, or had repeated swelling of any of the following areas?

If yes, please explain below.

Head Yes No _____

Neck Yes No _____

Chest Yes No _____

Shoulder Yes No _____

Elbow Yes No _____

Forearm Yes No _____

Wrist Yes No _____

Hand Yes No _____

Back Yes No _____

Hip Yes No _____

Thigh Yes No _____

Knee Yes No _____

Ankle Yes No _____

Calf Yes No _____

Foot Yes No _____

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