

# Lindsey Wilson College Student-Athlete Health History

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address:
Sport:
Personal Physician:

**Please check "Yes" or "No" for each item below. Explain "Yes" answers in space provided below.**

	Yes	No		Yes	No
Do you have any allergies (examples: pollen, medicine, food or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
Do you cough, wheeze, or have trouble breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a sprain, strain, swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a medical illness or injury since your last checkup or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been hospitalized over night?	<input type="checkbox"/>	<input type="checkbox"/>	<b>If yes, check appropriate box and explain below.</b>		
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Head <input type="checkbox"/>	Elbow <input type="checkbox"/>	Hip <input type="checkbox"/>
Are you currently taking any prescriptions or nonprescription (over the counter) medications or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	Neck <input type="checkbox"/>	Forearm <input type="checkbox"/>	Thigh <input type="checkbox"/>
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	Back <input type="checkbox"/>	Wrist <input type="checkbox"/>	Knee <input type="checkbox"/>
Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Chest <input type="checkbox"/>	Hand <input type="checkbox"/>	Shin/Calf <input type="checkbox"/>
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder <input type="checkbox"/>	Finger <input type="checkbox"/>	Ankle <input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Upperarm <input type="checkbox"/>	Foot <input type="checkbox"/>	
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Do you want to weigh more or less than you do now? <input type="checkbox"/> <input type="checkbox"/>		
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	Do you lose weight regularly to meet weight requirements for your sport? <input type="checkbox"/> <input type="checkbox"/>		
Have you ever had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	Do you feel stressed out? <input type="checkbox"/> <input type="checkbox"/>		
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	Record the dates for your most recent immunizations (shots) for:		
Has any family member or relative died of heart problems or of sudden death before the age of 50?	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____ Measles _____		
Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____ Chickenpox _____		
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis _____		
Is there a history of Marfan's Syndrome in your family?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Females only</b>		
Is there a history of premature (prior to age 50) onset of diabetes in your family?	<input type="checkbox"/>	<input type="checkbox"/>	When was your first menstrual period? _____		
Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period? _____		
Have you ever been knocked out, became unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	How much time do you usually have from the start of one period to the start of another? _____		
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had in the last year? _____		
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	What was the longest time between periods in the last year? _____		
Have you ever had numbness or tingling in your arms, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	I have received information about Hepatitis B and Meningitis and the vaccinations. <input type="checkbox"/> yes <input type="checkbox"/> no		
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Explain Yes answers here:</b>		
Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
			_____		
			_____		

**Emergency Contact Information:**

Name: _____	Work Phone: _____	Home Phone: _____
Cell Phone # _____	E-Mail Address _____	
Name: _____	Work Phone: _____	Home Phone: _____
Cell Phone # _____	E-Mail Address _____	

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

Signature of Student: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Lindsey Wilson College  
Pre-participation Physical Evaluation**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ % of Body Fat (optional): \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_\_

Vision R 20/: \_\_\_\_\_ L 20/: \_\_\_\_\_ Corrected: Y N Pupils: Equal: \_\_\_\_\_ Unequal: \_\_\_\_\_

**Medical**

	Normal	Abnormal Findings	Initials
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

**Musculoskeletal**

	Normal	Abnormal Findings	Initials
Neck			
Back			
Shoulder/Arm			
Elbow/Arm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

**Clearance**

- Cleared
- Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_
- Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

**Recommendations:**

\_\_\_\_\_

\_\_\_\_\_

Name of Physician (print/type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_