Clarkson University Athletic Training Department Medical History

Name:____ Sex:___ DOB:_______

Sport:_________________________ Date:____________ SSN:________________

Student ID:______________ Campus Address:_______________________________

School Phone:____________ Cell Phone:_____________ Email:________________

Emergency Contact:_______________________________ Phone:_______________

I. General Medical Information

1. Have you ever been hospitalized? YES NO
If yes when and why?____
____
____

2. Have you ever been diagnosed with any chronic medical condition? YES NO
If yes list condition with date(s)_________________________________
____
____

3. Have you ever had surgery? YES NO
If yes list with date(s)____
____
____

4. Do you have any allergies? YES NO
If yes list and explain____
____

5. Are you currently or have you ever taken any medications? YES NO
If yes list and explain____
____

6. Are you taking any supplements? YES NO
If yes list and explain____

7. Have you ever passed out during or after exercise? YES NO
8. Have you ever had chest pain during or after exercise? YES NO
9. Do you tire more quickly than your friends during exercise? YES NO
10. Have you ever had high or low blood pressure? YES NO
11. Have you ever had high cholesterol? YES NO
12. Have you ever been told you have a heart murmur? YES NO
13. Has a family member died before age 50? YES NO
14. Has anyone in your family been diagnosed with heart conditions? YES NO

Please explain yes answers for questions 7-14_________________________________
____
____

Indicate if you or anyone in your family have or have had any of the following illnesses or disorders by marking (S) for self and (F) for family.

	YES	NO	DATE(S)
Mononucleosis	___	___	________________
Hepatitis	___	___	________________
Asthma	___	___	________________
Diabetes	___	___	________________
Epilepsy or Convulsive Disorder	___	___	________________
Rheumatic or Scarlet Fever	___	___	________________
Anemia (include Sickle Cell)	___	___	________________
Heart Disorder	___	___	________________
Respiratory Disorder	___	___	________________
Kidney Disorder	___	___	________________
Gastrointestinal Disorder	___	___	________________
Genitourinary Disorder	___	___	________________
Eye, Ear, Nose Disorder	___	___	________________
Other Organ Disorder_______________________	___	___	________________
Absence of Paired Organ_____________________	___	___	________________
Concussion: Number_____	___	___	________________
Frequent or Severe Headaches	___	___	________________
History of Fainting or Dizziness	___	___	________________
Thyroid Disorder	___	___	________________
Heat Stroke	___	___	________________
Depression	___	___	________________
Anxiety	___	___	________________

II. Specific Medical Information

1. **Have you ever NOT been cleared to participate in a sport? YES NO**
   If yes explain____
   ____
2. **Do you wear glasses or contacts? YES NO**
3. **Do you have any skin problems? YES NO**
   If yes explain____
4. **Do you have any special equipment (pads, braces, etc.)? YES NO**
   If yes explain____
5. **Do you have metal anywhere on or in your body (pins, screws, etc)? YES NO**
   If yes explain____
6. **Do you have hearing impairment? YES NO**
7. **Do you wear any dental appliances? YES NO**

III. Orthopedic Information

Indicate if you have had any musculoskeletal injury to the following areas. Check right or left (if needed), indicate what type of injury (fracture, sprain, etc.), give date(s), and give any description that may help the CUAT staff in future evaluations.

	Right	Left	Type	Date	Description
Neck	______	_____	_______	________	______________
Back	______	_____	_______	________	______________
Knee	______	_____	_______	________	______________
Ankle	______	_____	_______	________	______________
Shoulder	______	_____	_______	________	______________
Elbow	______	_____	_______	________	______________
Foot	______	_____	_______	________	______________
Lower Leg	______	_____	_______	________	______________
Upper Leg	______	_____	_______	________	______________
Hip	______	_____	_______	________	______________
Upper Arm	______	_____	_______	________	______________
Forearm	______	_____	_______	________	______________
Wrist	______	_____	_______	________	______________
Hand	______	_____	_______	________	______________
Head	______	_____	_______	________	______________
Chest	______	_____	_______	________	______________
Abdomen	______	_____	_______	________	______________

Do you have any other type of illness/condition/injury which we should be aware of?

____

____

____

I hereby state that all information provided is current and accurate. I understand that providing false information or not disclosing a complete medical history may impede my recovery and treatment should re-injury occur. It may also cause medical insurance payment problems.

____ ____________________

Student Athlete Signature **Date**

____ ____________________

Parent/Guardian Signature If Under 18 **Date**