

HILLSDALE COLLEGE ATHLETIC MEDICINE HISTORY AND PHYSICAL

Name _____
Home Address _____
Phone _____
DOB _____

Date _____ SS# _____
School Address _____
School Phone: _____
Email _____

FATHER/GUARDIAN INFORMATION

Father's Name _____
Social Security No. _____
Date of Birth _____
Address _____
Employer _____
Address _____
Telephone _____

MOTHER/GUARDIAN INFORMATION

Mother's Name _____
Social Security No. _____
Date of Birth _____
Address _____
Employer _____
Address _____
Telephone _____

Vaccines (indicate year of last): Tetanus _____ Flu _____ Pneumonia _____ Other _____

MEDICAL HISTORY

Have you ever had or been diagnosed with any of the following? Check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> headache/migraine | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> dizziness/vertigo | <input type="checkbox"/> lupus/shoguns disease |
| <input type="checkbox"/> neck pain/fractures | <input type="checkbox"/> lyme disease |
| <input type="checkbox"/> cervical disk degeneration | <input type="checkbox"/> fibromyalgia |
| <input type="checkbox"/> thyroid problems | <input type="checkbox"/> gout/psoriasis |
| <input type="checkbox"/> chest pain/angina | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> heart attack/myocardial infarction | <input type="checkbox"/> liver disease/hepatitis |
| <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> chrosis |
| <input type="checkbox"/> coronary heart disease | <input type="checkbox"/> renal disease or failure |
| <input type="checkbox"/> irregular heartbeats/arrythmia | <input type="checkbox"/> anemia |
| <input type="checkbox"/> heartburn/GERD | <input type="checkbox"/> asthma/bronchitis |
| <input type="checkbox"/> hiatial hernia | <input type="checkbox"/> emphysema |
| <input type="checkbox"/> peptic ulcer disease | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> cancer-what type: _____ |
| <input type="checkbox"/> stroke/CVA | <input type="checkbox"/> psychological disorders: |
| <input type="checkbox"/> vascular disease | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> depression |
| <input type="checkbox"/> epilepsy/tremors | <input type="checkbox"/> schizophrenia |
| <input type="checkbox"/> seizures | <input type="checkbox"/> bipolar disorder |
| <input type="checkbox"/> weakness of extremities | <input type="checkbox"/> Other: |
| <input type="checkbox"/> numbness/tingling sensation | _____ |
| <input type="checkbox"/> polio | _____ |
| <input type="checkbox"/> arthritis | _____ |
| <input type="checkbox"/> rheumatoid arthritis | _____ |

FRACTURE OF BONES

Bone: _____ Date: _____ Result: _____
Bone: _____ Date: _____ Result: _____
Bone: _____ Date: _____ Result: _____
Bone: _____ Date: _____ Result: _____

SURGERIES / HOSPITALIZATIONS

Surgery	Date	Complications
_____	_____	_____
_____	_____	_____

Have you ever had general anesthesia? yes no
Have you experienced problems with anesthesia? yes no If yes, describe: _____

SOCIAL HISTORY

Work in the home: yes no Student
Marital Status: Single Married Divorced Separated Widowed

