Colby-Sawyer College

Athletic Participation Medical History

Name: _____ Date Of Birth: _____

Sport: _____ Telephone #: _____ Ext: _____

Have you had or do you now have the following? Please check appropriate box:

	Yes	No		Yes	No
Seasonal allergies/hay fever	☐	☐	High Blood Pressure	☐	☐
Asthma (wheezing)	☐	☐	Persistent Cough	☐	☐
Hives or rash (exercise related)	☐	☐	Chest pain with exercise/exertion	☐	☐
Bee-sting allergy	☐	☐	Dizziness or fainting with exercise	☐	☐
Food allergies	☐	☐	Heart palpitations	☐	☐
Do you smoke?	☐	☐	Irregular heart rate	☐	☐
Use an Epi-pen?	☐	☐	Shortness of breath	☐	☐
			Near fainting episodes	☐	☐
Headaches/migraines	☐	☐	Heart murmur	☐	☐
Brain concussion/Knocked out	☐	☐	Congenital heart conditions	☐	☐
Skull fracture/Head injury	☐	☐	Had a family member died suddenly before the age of 50?	☐	☐
Faint easily or often	☐	☐	Family History of Marfan Syndrome?	☐	☐
Seizure disorder	☐	☐	Family History of heart disease?	☐	☐
Use medications for ADD/ADHD?	☐	☐			
			Gastrointestinal conditions	☐	☐
Do you wear glasses or contacts?	☐	☐	Celiac/Sprue Disease	☐	☐
Temporary loss of vision	☐	☐	Chronic diarrhea/constipation	☐	☐
Are you color blind?	☐	☐	History of eating disorder?	☐	☐
Very bad (impaired) vision in one eye or missing an eye?	☐	☐	Dietary restrictions? (Please explain below)	☐	☐
			Do you use any nutritional supplements?	☐	☐
Hearing loss	☐	☐	Do you take vitamins?	☐	☐
Perforated eardrum	☐	☐	Difficulty swallowing	☐	☐
Chronic discharge from ear(s)	☐	☐	Chronic heartburn	☐	☐
Recurrent ear infections	☐	☐	Are you trying to gain weight?	☐	☐
			Are you trying to loose weight?	☐	☐
Sinus Infections	☐	☐	Diabetes	☐	☐
Broken nose	☐	☐	Hernia	☐	☐
Dental plate/dentures/braces	☐	☐	Kidney Problems	☐	☐
			Loss of function or absence of a testicle (men)	☐	☐
Had a sprain, strain, or swelling after injury that has kept you from participating in practice/games?	☐	☐	Recurrent rash	☐	☐
Any other problems with pain, swelling in any muscles, tendons, bones or joints?	☐	☐	Fungus infection	☐	☐
History of back problems? Scoliosis?	☐	☐	Athletes foot	☐	☐
Any numbness/tingling in arms, hands legs or feet?	☐	☐	Recurrent boils	☐	☐
Had a stinger, burner or pinched nerve?	☐	☐	Anemia	☐	☐
Do you use special protective or corrective equipment or devices?	☐	☐	Tendency to bleed or bruise easily	☐	☐
Musculoskeletal genetic/conditions	☐	☐	Thyroid disorder	☐	☐
			Immune deficiency conditions	☐	☐

If you answered YES to any of the above question, please explain below:

_____

_____

_____

_____

_____

Women Only:			**Yes**	**No**
How old were you when you had your first period?	_____	Do you experience cramps	☐	☐
How long do your periods last?	_____	History of abnormal Pap test	☐	☐
How many periods have you had in the last 12 mos?	_____	Using birth control pills/hormones	☐	☐
Date of last pelvic exam/Pap test	_____	History of frequent urinary infections?	☐	☐

If you have answered YES to any of the above questions, please explain below:

_____

_____

_____

	Yes	**No**
Have you been hospitalized or had a major illness?		
Are you currently recovering from an illness or injury?	☐	☐
If **Yes** please explain: _____		

Any **Allergies** to medications?	☐	☐
If **Yes** please list:		

Have you traveled outside of the United States?	☐	☐
If **Yes** please list when/where:		

Are you currently using: medications, vitamins or supplements?	☐	☐
If **Yes** please list: _____		

Please check any that apply to you:

- ☐ Tired most of the time (no energy)
- ☐ Inability to focus/concentrate
- ☐ I am homesick
- ☐ I do not like my body
- ☐ Overwhelmed with life's responsibilities
- ☐ I cut myself to relieve stress
- ☐ I often skip meals
- ☐ I am worried about my health
- ☐ Overwhelmed academically
- ☐ Memory Problems
- ☐ I'm vomiting after I eat
- ☐ Experiencing frequent Headaches
- ☐ Problems with my Professor/s
- ☐ Family member sick/chronic illness
- ☐ I am taking laxatives after eating
- ☐ Parents going through/or are divorced.
- ☐ Lack of Motivation
- ☐ I can't fall asleep
- ☐ Wake up a lot at night
- ☐ Not exercising
- ☐ Feeling Depressed
- ☐ I can't control my anger
- ☐ I often cry
- ☐ Experiencing Anxiety
- ☐ Panic attacks
- ☐ I'm sick a lot
- ☐ Exercising all of the time
- ☐ Family/friends in the Military
- ☐ Avoiding crowds
- ☐ Roommate difficulties
- ☐ Lacking Support system
- ☐ Experienced death of loved one
- ☐ Worry all of the time
- ☐ Spend a lot of time alone
- ☐ Irritability
- ☐ I want to sleep all of the time
- ☐ I'm really sad most of the time
- ☐ Eating too much junk food
- ☐ Wish I was someplace else
- ☐ Feeling moody a lot
- ☐ I am lonely
- ☐ I avoid the dining hall
- ☐ I think about death a lot
- ☐ I think how I might kill myself
- ☐ Relationship difficulties
- ☐ Time management issues
- ☐ Experiencing stomach aches
- ☐ Not enjoying academic classes
- ☐ I am supporting a friend going through a difficult time.
- ☐ Experienced an encounter with the law/judicial system
- ☐ I find myself using Alcohol &/or Drugs as a way to relax.
- ☐ People are concerned about my Alcohol &/or Drug use.

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

_____ _____

Signature of athlete Date

_____ _____

Signature of provider (I have reviewed the medical history) Date

Colby-Sawyer College

ATHLETIC PARTICIPATION PHYSICAL EXAM

NAME _____ **D.O.B.** _____

BP		**Pulse**		**Height**		**Weight**	**BMI**
							Right eye: 20/
Hgb/Hct		**UA**		**Glasses or Contacts?**			**Left eye: 20/**
							Both eyes: 20/
Date of last: Td/ Tdap			**Prosthesis:**				**Color blind:**

History of chronic allergies/illness/conditions _____

MEDICATIONS: _____

MEDICAL EXAM	WNL	COMMENT
Dental/Mouth		
EYES/FUNDUS		
EARS/NOSE/THROAT		
HEAD/NECK		
SKIN/SCALP		
LYMPHATICS		
THORAX		
LUNGS		
HEART		
ABDOMEN		
HERNIA		
GENITALIA		
MUSCULOSKELETAL		
NEUROLOGIC		
EXTREMITIES		

Clear for full Participation _____ **Cleared with following conditions:** _____

Summary: _____

Concerns: _____

_____ _____

Examiner's signature and title **Date of exam**

Address: _____ **Phone:** _____

Revised 6-09