

SEATTLE PACIFIC UNIVERSITY

Athletic Medical History Form

(Must be submitted annually by all athletes)

TODAY'S DATE: _____

NAME: _____
Last First Middle

SPORT(S): _____

BIRTHDATE: _____ AGE: _____ SEX: _____

PERMAMENT ADDRESS: _____

Number Street

City State Zip Code

Area Code Phone Number

CAMPUS ADDRESS: _____

Number Street

City State Zip Code

Area Code Phone Number

Email Address

FATHER'S INFORMATION: Living _____ Deceased _____

NAME: _____
Last First Middle

ADDRESS: _____
Number Street

City State Zip Code

Area Code Phone Number

MOTHER'S INFORMATION: Living _____ Deceased _____

NAME: _____
Last First Middle

ADDRESS: _____
Number Street

City State Zip Code

Area Code Phone Number

EMERGENCY INFORMATION:

NAME: _____
Last First Relationship

Work Phone Number

Home Phone Number

OVER

Please circle YES or NO for present or pre-existing conditions.

MUSCLE / BONES / JOINTS

Surgery / Surgical Procedures **YES NO**
 Fracture / Broken Bones **YES NO**
 Dislocations / Subluxations/ Separations **YES NO**
 Sprain / Strain **YES NO**
 Tendonitis / Synovitis **YES NO**
 Cartilage Injury **YES NO**
 Muscle Spasm **YES NO**
 Joint Injury **YES NO**
 Other Conditions **YES NO**

HEAD / NECK / BACK

Surgery / Surgical Procedures **YES NO**
 Concussion / "Knocked Out" **YES NO**
 Closed Head Injury **YES NO**
 Headaches **YES NO**
 Impingement / Pinch Nerve **YES NO**
 Stinger / Burners **YES NO**
 Head, Neck, or Back Fractures **YES NO**
 Head, Neck or Back Injury / Pain **YES NO**
 Other conditions **YES NO**

CARDIOVASCULAR / PULMONARY

Heart Murmur **YES NO**
 Cardiovascular Disease **YES NO**
 Elevated Blood Pressure **YES NO**
 Other Heart Conditions **YES NO**
 Asthma / Exercise-Induced Asthma **YES NO**
 Pneumonia **YES NO**
 Other Lung Conditions **YES NO**

EYES / EARS / NOSE/ DENTAL

Glasses / Contacts **YES NO**
 Loss of Vision in either eye **YES NO**
 Loss of Hearing **YES NO**
 Frequent Nose Bleeds **YES NO**
 Dentures **YES NO**
 Missing Teeth **YES NO**
 Other Conditions **YES NO**

GENERAL

Surgery / Surgical Procedures **YES NO**
 Heat Exhaustion / Heat Stroke **YES NO**
 Hyperventilated **YES NO**
 Prescribed medications **YES NO**
 Fainting / "Black Outs" **YES NO**
 Hay fever **YES NO**
 Other Conditions **YES NO**

DISEASES / ILLNESSES

Seizures **YES NO**
 Diabetes **YES NO**
 Mononucleosis **YES NO**
 Bacterial / Viral Infection **YES NO**
 Stomach Ulcers **YES NO**
 Hernia **YES NO**
 Other Conditions **YES NO**

ALLERGIES

Drugs **YES NO**
 Food **YES NO**
 Insects **YES NO**
 Other known allergies **YES NO**

FEMALES ONLY

Menstruate **YES NO**
 Other Conditions **YES NO**

OTHER CONDITIONS

YES NO

If you answered YES to any of the above questions, please explain including dates, affected side, duration and treatment. If you need more space, please use an additional page.

DATES (include duration of injury/illness)	INJURY / ILLNESS (include affected side)	TREATMENT
1		
2		
3		
4		
5		
6		

SIGNATURE

DATE