



# STUDENT HEALTH SERVICES

## ATHLETIC HEALTH EVALUATION INTERIM MEDICAL HISTORY

**RETURNING ATHLETE:** This form is to be used for all athletic students who have been through the medical evaluation process in previous years. Failure to provide accurate information could affect your playing eligibility.

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Previous sport(s) at SRJC: \_\_\_\_\_ Year: \_\_\_\_\_

Has your medical insurance changed in last year? Yes  No

If you answered yes, please update insurance information.

New insurance carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

**Since your last physical clearance have you had any of the following? (If Yes, please explain)**

	Yes	No	
Referred to the Training Room for treatment	<input type="checkbox"/>	<input type="checkbox"/>	Explain _____
Broken or dislocated bones	<input type="checkbox"/>	<input type="checkbox"/>	Explain _____
Severe sprain or joint injury	<input type="checkbox"/>	<input type="checkbox"/>	Explain _____
Concussion/loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	Explain _____
Serious accident(s)	<input type="checkbox"/>	<input type="checkbox"/>	Explain _____
Hospitalization(s)	<input type="checkbox"/>	<input type="checkbox"/>	Explain _____
Surgery (or recommended)	<input type="checkbox"/>	<input type="checkbox"/>	Explain _____
Back or neck problems	<input type="checkbox"/>	<input type="checkbox"/>	Explain _____
New allergies	<input type="checkbox"/>	<input type="checkbox"/>	Explain _____
New illnesses	<input type="checkbox"/>	<input type="checkbox"/>	Explain _____
Red shirted in last season	<input type="checkbox"/>	<input type="checkbox"/>	

**Please check the following if you have developed any NEW problem in the following areas since your last physical clearance.**

- |                               |                                |   |   |  |
|-------------------------------|--------------------------------|---|---|--|
| <input type="checkbox"/> Skin | <input type="checkbox"/> Neck  | <input type="checkbox"/> Back           | <input type="checkbox"/> Bowel Habits           | <input type="checkbox"/> Nose, Mouth, Throat |
| <input type="checkbox"/> Head | <input type="checkbox"/> Lungs | <input type="checkbox"/> Stomach        | <input type="checkbox"/> Genitals (menstrual)   | <input type="checkbox"/> Muscles             |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Heart | <input type="checkbox"/> Urinary Track  | <input type="checkbox"/> Shoulders, Arms, Hands |  |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Knees | <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> Hips, Legs, Feet       |  |

1. Have you ever fainted during exercise? Yes  No

2. Has any blood relative had heart problems before the age of 50? Yes  No

3. Do you know any medical reason that might limit your participation in sports? \_\_\_\_\_

4. Are you taking any medications on a regular basis (daily/weekly)? \_\_\_\_\_

5. Are you allergic to any medications? Yes  No  If yes, please list: \_\_\_\_\_

6. Other / comments: \_\_\_\_\_

**I certify that the information given is correct to the best of my knowledge.**

**Student's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reviewed by (RN/FNP):** \_\_\_\_\_ **Date:** \_\_\_\_\_