

# Moravian College Returning Athlete Medical History Survey

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Sport(s): \_\_\_\_\_ Grade: SO JR SR 5<sup>th</sup> year

Cell phone number: \_\_\_\_\_

The following is an update of your personal medical history for the past year. You are required to provide accurate information with regard to **ALL** questions. This form will be kept in your file in the Athletic Training Office.

***Please answer all of the following questions. Circle either YES or NO for each question. Explain any "yes" answers in the spaces provided.***

YES NO 1. Do you have any known allergies?

YES NO 2. Are you currently taking any medications, including over the counter?

YES NO 3. Are you taking any nutritional supplements?

YES NO 4. Have you been hospitalized in the past year?

YES NO 5. Have you had any surgeries in the past year?

YES NO 6. Did you sustain any injuries during your season last year?

YES NO 7. Have you ever fainted/felt dizzy during exercise?

YES NO 8. Have you ever had chest pain, shortness of breath, wheezing during exercise?

YES NO 9. Have you ever had heart trouble?

YES NO 10. Have you ever had high blood pressure?

YES NO 11. Have you ever had heat related illness? (cramps, dizziness, fainting)

YES NO 12. Have you ever been diagnosed with a concussion?

YES NO 13. Do you have any other medical problems?

(Including, but not limited to, mono, hepatitis, AIDS, asthma, diabetes, loss or impaired function of any organ)

YES NO 14. Do you have any menstrual irregularities/problems?

YES NO 15. Have you ever injured (sprained, strained, dislocated, fractured) any of the following?

Neck\_\_\_\_ Shoulder\_\_\_\_ Elbow\_\_\_\_ Wrist\_\_\_\_ Hand\_\_\_\_ Fingers\_\_\_\_

Chest\_\_\_\_ Hip\_\_\_\_ Knee\_\_\_\_ Ankle\_\_\_\_ Foot\_\_\_\_ Toes\_\_\_\_ Back\_\_\_\_

Head\_\_\_\_

If you have checked any of the above please explain in the space below.

**If you have been treated by a physician for any injury / illness during the past 3 months; please provide documentation stating the diagnosis, treatment and your clearance to participate in intercollegiate athletics.**

I acknowledge that all of the information that has been provided in answering these questions is accurate and complete to the best of my knowledge, and that there has been no attempt to withhold any information that may adversely affect my health and performance as a student athlete.

Students Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**TO BE COMPLETED BY MORAVIAN COLLEGE SPORTS MEDICINE / ATHLETIC TRAINING STAFF**

Height\_\_\_\_\_ Weight\_\_\_\_\_ B/P\_\_\_\_\_ Pulse\_\_\_\_\_

Clearance for sports participation:

- A. Cleared
- B. Cleared after completing evaluation / rehab for:
- C. Not cleared due to:
- D. Restrictions:

Notes:

Name of Examiner: \_\_\_\_\_ MD, DO, ATC

Signature of Examiner: \_\_\_\_\_ Date: \_\_\_\_\_