

MMI STUDENT-ATHLETE MEDICAL HISTORY FORM

Name: _____ Sport: _____

SS#: _____ Date Of Birth: _____ Year Of Eligibility: _____

Please answer all of the following questions. Please circle either YES or NO for each question and then explain every "YES" answer in the space provided: THANK YOU

FAMILY HISTORY

Has anyone in your immediate family had any of the following:

EXPLANATION

Heart Disease	YES	NO	High Blood Pressure	YES	NO	
Sudden Death (before 50)	YES	NO	Stroke	YES	NO	
Epilepsy	YES	NO	Diabetes	YES	NO	
Cancer	YES	NO	Tuberculosis	YES	NO	
Migraine Headaches	YES	NO	Asthma	YES	NO	
Sickle Cell Anemia or Trait	YES	NO	Marfan's Syndrome	YES	NO	

PERSONAL HISTORY

EXPLANATION

1. Have you ever passed out during or after exercise? YES NO
 Have you ever dizzy or lightheaded during or after exercise? YES NO
 Have you ever had chest pain during or after exercise? YES NO
 Have you ever had shortness of breath during or after exercise? YES NO
 Do you tire more quickly than your friends during exercise? YES NO
 Have you ever had high or low blood pressure? YES NO
 Have you ever been told that you have a heart murmur? YES NO
 Have you ever had a racing heart or skipped heartbeats? YES NO
 Has anyone in your family died of heart problems or a sudden death before age 50? YES NO

2. Have you ever had a head injury? YES NO
 Have you ever been "knocked out" or suffered a concussion? YES NO
 If YES , how many have you had? _____ List dates of incidents: _____
 Do you have recurring headaches or migraines? YES NO
 Have you ever had a stinger, burner or pinched nerve? YES NO
 If YES , how many have you had? _____ List dates of incidents: _____

3. Have you ever had heat or muscle cramps? YES NO
 Have you ever been dizzy or passed out in the heat? YES NO
 Have you ever suffered a heat-related illness? YES NO
 Have you received intravenous fluids for a heat-related problem? YES NO

4. Have you ever been diagnosed with asthma and/or exercised induced asthma? YES NO
 If YES, list the medication(s) that you take: _____
 Do you have trouble breathing or do you cough during or after activity? YES NO
5. Have you ever had any of the following? Please circle the appropriate condition:

Diabetes	Epilepsy	YES	NO	
Sickle Cell Anemia	Marfan's Syndrome	YES	NO	
Hepatitis	Jaundice	YES	NO	
Mononucleosis	Tuberculosis	YES	NO	
Anemia	Leukemia	YES	NO	
Ulcers	Colitis	YES	NO	
Mumps	Measles	YES	NO	
Hernia	Kidney or Bladder Problems	YES	NO	
Depression	Mental Illness	YES	NO	
Insomnia	Drug or Alcohol Addiction	YES	NO	

6. Do you have a loss or impaired function of any paired organ? YES NO
 (eyes, ears, lungs, kidneys, testicles, or ovaries)

7. Do you wear glasses? YES NO
 Do you wear contact lens? YES NO
 Do you use protective eye wear? YES NO

8. Do you wear any dental appliance (bridge, crown, plate)? YES NO

9. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc)? YES NO _____

10. Do you have any skin problems (itching, rashes or acne)? YES NO _____

11. **FOR FEMALES ONLY:**

Have you had menstrual periods within the past 12 months? YES NO _____

If YES, how many? _____ When was your most recent menstrual period? _____

Do you have painful or heavy menstrual periods? YES NO _____

Do you take any medications during your menstrual periods? YES NO _____

Have you had a pelvic examination within the last year? YES NO _____

12. Have you ever injured (sprained, strained, dislocated, fractured, or had repeated swelling) any of the following:

EXPLANATION

Head/Face	YES	NO	_____
Neck	YES	NO	_____
Chest	YES	NO	_____
Shoulder	YES	NO	_____
Elbow	YES	NO	_____
Wrist/Hand	YES	NO	_____
Thumb/Fingers	YES	NO	_____
Back	YES	NO	_____
Hip/Thigh	YES	NO	_____
Knee	YES	NO	_____
Lower Leg	YES	NO	_____
Ankle	YES	NO	_____
Foot/Toes	YES	NO	_____

13. Name any recent injuries or illnesses within the last 18 months which resulted in surgery or hospitalization:

14. Name any recent injuries or illnesses within the last 18 months which resulted in lost practice or playing time:

15. Are you currently taking **ANY MEDICATION** on a daily basis? YES NO

If, YES, please list the medication and the conditions you are taking it for:

Medication

Condition

16. Are you allergic to anything? (Medications, Food, Environmental, Insect Bite/Sting, Etc.) YES NO

If, YES, please list everything you are allergic to:

THE FOLLOWING CONDITIONS REQUIRE A LETTER FROM YOUR ATTENDING PHYSICIAN CLEARING YOU FROM THE INJURY OR DISORDER BEFORE YOU ARE ALLOWED TO PARTICPATE:

- A) Heart murmurs and heart abnormalities
- B) Bone and joint surgeries performed within one year of participation at MMI
- C) Any medical illness or disease which limits physical participation

Any medical information withheld, incomplete, or incorrect relieves Marion Military Institute from all medical and legal liability and may disqualify you from participation on any MMI athletic teams. I understand the above statement and the preceding questions have been answered completely and truthfully to the best of my knowledge.

Student-Athlete's Signature _____ Date: _____

Parent/Guardian Signature _____ Date: _____

(MUST BE SIGNED BY A PARENT OR GUARDIAN FOR ALL STUDENT-ATHLETES)