ELMS COLLEGE STUDENT MEDICAL HISTORY

Last Name: First Name: M.I.:

Age: DOB: Gender: Class:

Home Address: Town/City:

State: Zip: Country: Birth Country:

Cell Phone: Email address:

Resident/Commuter: Dorm: Room #

Emergency Contact: Relationship: Phone #:

ALL INFORMATION IS CONFIDENTIAL

INFORMATION WILL NOT BE RELEASED WITHOUT YOUR KNOWLEDGE AND WRITTEN CONSENT

PLEASE NOTE THE FOLLOWING: MEDICAL CLEARANCE MAY BE DENIED IF 'YES' RESPONSES ARE NOT COMPLETELY EXPLAINED. PARENT/GUARDIAN SIGNATURE IS REQUIRED FOR STUDENTS UNDER THE AGE OF 18.

Family History

	Living or Deceased	Present Age or Age of Death	State of Health or cause of death
Father			
Mother			
Siblings: M/F			
M/F			
M/F			
M/F			
Spouse			
Children M/F			
M/F			
M/F			

Has anyone in your family had:	**Yes**	**No**	**Relationship**	**Explanation**
Sudden Death before age 50				
Disability from heart disease (younger than 50)				
Hypertrophic or dilated cardiomyopathy				
Long QT syndrome				
Heart arrhythmia				
Marfan Syndrome				
Blood Disorder/Hemophilia				
High/Low Blood Pressure				
Tuberculosis				
Kidney Disease				
Diabetes				
Cancer				
Seizures/Epilepsy				
Stroke				
Asthma				
Mental Disorder				
Drug and/or Alcohol Dependency				

ELMS COLLEGE STUDENT MEDICAL HISTORY

Personal General Medical History

Do you wear glasses?	Y	N
Do you wear contacts?	Y	N
Do you regularly wear hearing aids or use any other auditory enhancement device?	Y	N
Do you wear orthotics?	Y	N

	Yes	No	If yes, list when and what for:
Have you ever been in a car accident? Any injuries?			
Have you ever been hospitalized?			
Have you ever had any surgeries?			
Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 2 years(other than routine check-ups?			
Has your physical activity been restricted at all within the last 5 years?			
Have you ever received treatment or counseling for a mental illness, personality or character disorder or emotional problem?			

Allergies: List ALL allergies you have to any drug, medication, food, or other environmental (bees, grass, etc.)

_____

_____

Do you carry an Epi-Pen? Y / N

Medications: List ALL medications that you are currently taking and include the dosage

_____

_____

Supplements: List ALL supplements that you are currently taking and include the dosage

_____

_____

Have you had any of the following:

	Y/N	Date of diagnosis/Incident	Ongoing Issue?
High/Low Blood Pressure	Y/N		Y/N
Sickle Cell Trait	Y/N		Y/N
Blood Disorder	Y/N		Y/N
Anemia/ Transfusions	Y/N		Y/N
Blood Clots	Y/N		Y/N
Hepatitis	Y/N		Y/N
HIV/AIDS	Y/N		Y/N
Sexually transmitted infections	Y/N		Y/N
Meningitis	Y/N		Y/N
Chicken Pox	Y/N		Y/N
Hay Fever	Y/N		Y/N
Measles	Y/N		Y/N

	Y/N	Date of diagnosis/Incident	Ongoing Issue?
Jaundice	Y/N		Y/N
Kidney Disease/Stones	Y/N		Y/N
Cancer/tumor/ cyst	Y/N		Y/N
Organ Removal/ Transplant	Y/N		Y/N
Disease or injury of the Muscles	Y/N		Y/N
Disease or injury of bones/joints	Y/N		Y/N
Stroke	Y/N		Y/N
Epilepsy/Seizure/other neurological issues	Y/N		Y/N
Weakness or paralysis	Y/N		Y/N
Headaches/ Migraines	Y/N		Y/N
Sinusitis	Y/N		Y/N
Recurrent colds	Y/N		Y/N

ELMS COLLEGE STUDENT MEDICAL HISTORY

German Measles/Rubella	Y/N		Y/N	Ear, nose, throat trouble	Y/N		Y/N
Mumps	Y/N		Y/N	Whooping cough	Y/N		Y/N
Malaria	Y/N		Y/N	Tuberculosis	Y/N		Y/N
Mononucleosis	Y/N		Y/N	Pneumonia	Y/N		Y/N
Appendicitis	Y/N		Y/N	Bronchitis	Y/N		Y/N
Thyroid Disease	Y/N		Y/N	Asthma	Y/N		Y/N
High/Low Blood Sugar	Y/N		Y/N	Gastrointestinal Condition	Y/N		Y/N
Recent weight change	Y/N		Y/N	Ulcer	Y/N		Y/N
Easy fatigue	Y/N		Y/N	Skin Condition	Y/N		Y/N
Back pain/ other problems	Y/N		Y/N	MRSA	Y/N		Y/N
				Heat Illness	Y/N		Y/N

Are you currently under the care of a doctor or other specialist for any of the above conditions? If yes, please explain. Y / N

_____

_____

_____

Cardiovascular History

Have you had any of the following?		
Unexplained fainting or near fainting?	Y	N
Recurring moments of feeling dizzy or light-headedness during or immediately after exercise?	Y	N
Chest pain, chest tightness or other discomfort in the chest during exercise?	Y	N
Feeling of your heart racing or skipping beats during exercise?	Y	N
Feeling of your heart racing or skipping beats at rest?	Y	N
Unexplained difficulty breathing during exercise?	Y	N
Heart murmur	Y	N
Rheumatic fever	Y	N

If you answered "yes" to any of the questions above, please explain in the lines below:

_____

_____

_____

Mental Health History

Have you ever had any of the following?		**Date of Onset**	**Ongoing?**
Depression	Y / N		Y / N
Anxiety	Y / N		Y / N
ADD/ADHD	Y / N		Y / N
Insomnia	Y / N		Y / N
Post-Traumatic Stress Disorder	Y / N		Y / N
Bi-polar disorder	Y / N		Y / N
Eating Disorder	Y / N		Y / N
Drug/ Alcohol Dependency	Y / N		Y / N
Other mental health condition not previously listed: _____	Y / N		Y / N

ELMS COLLEGE STUDENT MEDICAL HISTORY

Concussion History

Have you ever sustained a serious head injury?	Y	N
Have you ever been hospitalized for a concussion or a head, neck, or spinal injury?	Y	N
Have you ever lost consciousness due to head injury/concussion?	Y	N

Number of diagnosed concussions: _____

Month/Year of concussion	Did it affect activities of daily living?(school, sports, etc.)	For how long?:
1.	Y / N	
2.	Y / N	
3.	Y / N	
4.	Y / N	

Diabetic History

Do you have a diabetic condition? Y /N

How often do you check your blood sugar levels each day: _____

Are you currently taking any medications to assist with the control of your diabetes? Y / N

If "yes", please list medications here (include dosage):_____

For FEMALES ONLY:

At what age was the onset of your first menstrual period:_____

Are your periods regular? Y / N

Interval: Every _____ days. Duration: _____ days.

Have you ever had amenorrhea (absence of period)? Y / N

Do you have cramps/ disability with your periods? Y / N

Emotional reaction: _____

Are you currently on any contraception? Y / N Type: _____

Menopause Y / N Age: _____

I hereby acknowledge that the responses provided above regarding my past and current medical history, or that of my child, are true, complete, and accurate to the best of my knowledge. I confirm that no medical information has been withheld and that I, or my child, have no abnormality, limitation, or restriction not mentioned in this record.

X_____Date:_____

Signature of Student

X_____Date:_____

Signature of Parent/Guardian (if student is under the age of 18)

- STOP HERE -

ALL STUDENTS PLANNING TO PARTICIPATE IN A NCAA REGULATED SPORT FOR ELMS COLLEGE MUST CONTINUE ON TO THE NEXT SECTION MARKED 'ATHLETES ONLY'. ALL OTHERS HAVE SUCCESSFULLY COMPLETED THEIR MEDICAL HISTORY FORM REQUIREMENTS AND SHOULD SUBMIT ONLY THE PAGES ABOVE.

ELMS COLLEGE STUDENT MEDICAL HISTORY

ATHLETES ONLY

This section is to be completed only by students participating in NCAA regulated sport(s) through Elms College.

Do you wear glasses to play sports? Y N

Do you wear contacts to play sports? Y N

Do you wear a brace or other supporting device during sports? Y N

Orthopedic Medical History

Lower Body	Y/N	Right/Left/Both	Injury/Injuries Description	Date of Injury/Injuries	Ongoing Issue?
Toes	Y / N	R / L / B			Y / N
Foot	Y / N	R / L / B			Y / N
Ankle	Y / N	R / L / B			Y / N
Knee	Y / N	R / L / B			Y / N
Hip	Y / N	R / L / B			Y / N
Shin Splints	Y / N	R / L / B			Y / N
Compartment Syndrome	Y / N	R / L / B			Y / N
Flat Feet	Y / N				Y / N
High Arches	Y / N				Y / N

Upper Body	Y/N	Right/Left/Both	Injury/Injuries Description	Date of Injury/Injuries	Ongoing Issue?
Fingers	Y / N	R / L / B			Y / N
Hand	Y / N	R / L / B			Y / N
Wrist	Y / N	R / L / B			Y / N
Forearm	Y / N	R / L / B			Y / N
Elbow	Y / N	R / L / B			Y / N
Upper Arm	Y / N	R / L / B			Y / N
Shoulder	Y / N	R / L / B			Y / N
Clavicle	Y / N	R / L / B			Y / N

Head/Neck/ Back/Torso	Y/N	Right/Left/Both	Injury/Injuries Description	Date of Injury/Injuries	Ongoing Issue?
Back/Spine	Y / N				Y / N
Neck/cervical spine	Y / N				Y / N
Abnormal Back Curves	Y / N				
Low Back Pain	Y / N				
Ribs	Y / N	R / L / B			Y / N
Abdomen	Y / N	R / L / B			Y / N
Chest	Y / N	R / L / B			Y / N
Facial fracture(nose, jaw, orbital socket)		R / L / B			
Eye injury		R / L / B			
Ear injury		R / L / B			

ELMS COLLEGE STUDENT MEDICAL HISTORY

ATHLETES ONLY

Are you currently under the care of a doctor, orthopedic, physical therapist or any other specialist for any of the injuries marked above? If yes, please list below: Y / N

_____

_____

_____

Have you had any surgeries for any of the above injuries? If yes, please list below. Y / N

_____

_____

_____

Have you ever been told by a physician NOT to play sports? If yes, please explain below. Y / N

_____

_____

_____

I hereby acknowledge that the responses provided above regarding my past and current medical history, or that of my child, are true, complete, and accurate to the best of my knowledge. I confirm that no medical information has been withheld and that I, or my child, have no abnormality, limitation, or restriction not mentioned in this record.

X_____ Date: _____

Signature of Student

X_____ Date: _____

Signature of Parent/Guardian (if student is under the age of 18)