

**RANDOLPH COLLEGE  
ATHLETE MEDICAL HISTORY**

**PERSONAL DATA**

Name \_\_\_\_\_ Year graduating college \_\_\_\_\_

(Last) (First) (MI)

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Sport(s) \_\_\_\_\_

Home Address \_\_\_\_\_

(Number and Street)

(City) (State) (Zip)

Athlete's Cell #: \_\_\_\_\_

School Address \_\_\_\_\_

(Dorm and Room #) (Room Phone #) (Box #)

**EMERGENCY INFORMATION:**

Home Phone # (\_\_\_\_) \_\_\_\_\_

Mother's name \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_

SS# \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_

Father's name \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_

SS# \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_

**HEALTH INSURANCE INFORMATION:** All lines must be completed

Insurance Company \_\_\_\_\_

Company Address \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policyholder Name \_\_\_\_\_

Policyholder Date of Birth \_\_\_\_\_

Policyholder Social Security # \_\_\_\_\_

**PLEASE PHOTOCOPY FRONT AND BACK OF INSURANCE CARD AND  
SUBMIT WITH THIS FORM**

**PERSONAL HEALTH HISTORY**

Tetanus (must be within last 10 years) \_\_\_\_\_  
(Date of last injection)

Hospitalization (Specify when and purpose of each hospitalization) (Inpatient or Outpatient)

\_\_\_\_\_

Allergies (Specify type)

Medication \_\_\_\_\_ Food \_\_\_\_\_

Bee stings \_\_\_\_\_ Dust/Pollen \_\_\_\_\_ Other \_\_\_\_\_

Medications (Please list all medications, prescription and over-the-counter, taken on a regular basis)

\_\_\_\_\_

Do you have any current medical problems? If yes, please explain:

\_\_\_\_\_

**REVIEW OF SYSTEMS: Check appropriate box**

**YES NO**

**If yes, explain and include the date.**

|                                |  |  |                           |
|--------------------------------|--|--|---------------------------|
| Head Injury                    |  |  |                           |
| Concussion                     |  |  |                           |
| Unconsciousness                |  |  |                           |
| Seizures                       |  |  |                           |
| Dizziness                      |  |  |                           |
| Fainting                       |  |  |                           |
| Heat Illness                   |  |  |                           |
| Family History Heart Disease   |  |  | Age diagnosed: Who:       |
| Marfan's Syndrome              |  |  |                           |
| Heart Murmur/Valve Disorders   |  |  |                           |
| Heart Palpitations/Arrhythmias |  |  |                           |
| High Blood Pressure            |  |  |                           |
| Low Blood Pressure             |  |  |                           |
| Shortness of Breath            |  |  |                           |
| Asthma                         |  |  |                           |
| Diabetes                       |  |  |                           |
| Bleeding Disorders             |  |  |                           |
| Eating Disorders               |  |  | How long:                 |
| Menstruation abnormalities     |  |  |                           |
| Severe Cramps                  |  |  |                           |
| Irregular Periods              |  |  | How many cycles per year: |
| Anemia                         |  |  |                           |
| Missing organs                 |  |  |                           |
| Other (specify):               |  |  |                           |

**MUSCULOSKELETAL SYSTEM (Indicate if you ever had any injury or problem related to the following areas.)**

**YES NO**

**If yes, explain and include the date.**

|                 |  |  |  |
|-----------------|--|--|--|
| Neck            |  |  |  |
| Shoulder        |  |  |  |
| Elbow           |  |  |  |
| Arm/Wrist/Hand  |  |  |  |
| Ribs/Torso      |  |  |  |
| Back            |  |  |  |
| Hip             |  |  |  |
| Thigh           |  |  |  |
| Knee            |  |  |  |
| Lower Leg/Shins |  |  |  |
| Ankle           |  |  |  |
| Foot            |  |  |  |
| Other           |  |  |  |

**EYES** Do you wear glasses? \_\_\_\_\_ Contact lenses? \_\_\_\_\_ Type \_\_\_\_\_

**TEETH** Do you have any caps? \_\_\_\_\_ Partial plates? \_\_\_\_\_ Dentures? \_\_\_\_\_

I hereby certify that the above information is correct and the health insurance information provided is complete and accurate.

Signature of athlete: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent/guardian if athlete is under 18: \_\_\_\_\_