Form A **Eligibility Year (Fr, So)** _____

Sport(s)

Jacksonville College Sports Medicine Medical History Form

Full Legal Name:		Gender: **M** **F**	Date of Birth:	Age:
Address while @ Jacksonville College:				
Email Address:		Cell or Contact Phone:		
1.	Please **circle** any/all medical problems that you have: None	Anemia	Anorexia	
	ADD/ADHD	Bipolar disorder	Bulimia	Asthma
	Elevated cholesterol	High blood pressure	Migraine headaches	Depression
	Seizure disorder	Thyroid disorder	Seasonal allergies	Other:
2.	List all medications that you take:			
3.	Do you have any medication allergies? No Yes If yes, please list:			
4.	List all vitamins/supplements that you take:			
5.	Are you allergic to bee stings? No Yes			
5.	List all surgeries that you have had (include dates):			
6.	Have you ever passed out while exercising? No Yes If yes, please explain:			
7.	Other than an isolated episode when you had not eaten for several hours, have you ever experienced chest pain or dizziness while exercising? No Yes If yes, please explain:			
8.	Has anyone in your family died from heart problems before the age of 50? No Yes. If yes, what was the cause? Please **circle** one: Heart attack Abnormal heart rhythm Cardiomyopathy Long QT Aneurysm Don't know Other:			
9.	Has a physician ever advised you **AGAINST** your participation in sports? No Yes If yes, why?			
10.	Do you have a heart murmur that requires you to take antibiotics prior to dental appointments? No Yes If yes, please explain:			
11.	Have you had a serious infection (mono, myocarditis, pneumonia) within the past year? No Yes If yes, please explain:			
12.	Do you have sickle cell trait? No Yes Don't know			
13.	Have you ever had heat exhaustion or heat stroke? No Yes If yes, what happened?			
14.	Do you recurrently experience muscle cramps while exercising? No Yes			
15.	Have you ever had a concussion? No Yes If yes, please list dates of them:			
16.	Have symptoms from a concussion ever lasted longer than a week? No Yes If yes, how long did they last?			
17.	Do you have normal vision in both eyes? Yes No If no, is vision corrected by glasses or contacts?			

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18.	Do you have normal hearing? Yes No
19.	Have you ever injured a muscle, tendon, ligament, joint or bone that caused you to miss more than a week of training/playing? No Yes If **yes**, please explain and list dates:
20.	Do you currently have any injuries that cause pain or limit participation in sports? No Yes If yes, please describe:
21.	Do you wear any type of brace or orthotics during athletic participation? No Yes If yes, what do you wear:
22.	Do you have monthly menstrual cycles? Yes No If no, how often do they occur?
23.	Do menstrual cycles last longer than 7 days? No Yes If yes, typically how long?

I hereby state that, to the best of my knowledge, the answers to the above questions are complete and correct.

Athlete's Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

(Required if athlete is under 18 years of age)