

MEDICAL HISTORY

(to be completed by student & signed by health professional)

Please complete this form before going to your health care professional for examination. This information is strictly for the use of the Student Health Center and will not be released to anyone without your knowledge and written consent.

Completion Date _____

Last Name (Student)	First Name	Middle	Sex <input type="checkbox"/> M <input type="checkbox"/> F	S.S. Number	Birthday
Permanent Mailing Address		City	State		ZIP
Home Phone	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		List Name of Varsity College Sport you are rostered on or N/A		

Height _____ Weight _____

1.) Do you have any allergies to medication? Yes No If yes, please list: _____

2.) Do you have any other allergies? Yes No If yes, please list with reactions: _____

3.) Do you carry an epi-pen? Yes No

4.) Current medications

5.) Have you ever been hospitalized? Yes No If yes, dates/reasons: _____

6.) Have you ever had surgery? Yes No If yes, dates/reasons: _____

7.) Have you ever been told by a health care provider to not partake in athletic activity? Yes No

If yes, please explain: _____

8.) Are you currently taking any supplements? Yes No If yes, please list: _____

9.) Are you currently trying to gain or lose weight? Yes No

If yes, please explain: _____

10.) Have you ever been diagnosed or treated for an eating disorder? Yes No

If yes, please explain: _____

11.) Have you ever seen a dietician or nutritionist for advice? Yes No

If yes, when and why: _____

12.) Do you smoke or vape? Yes No If yes, how much per day? _____

13.) Do you use any smokeless tobacco products? Yes No If yes, how much per day? _____

14.) Do you drink alcohol or use marijuana? Yes No If yes, how often per day? _____

15.) Have you ever been dizzy or passed out from the heat Yes No

16.) Have you ever had heat cramps? Yes No

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17.)	Cardiac History [please check X in the yes or no boxes below]	YES	NO
a.	Have you ever passed out during exercise?		
b.	Have you ever been dizzy during exercise?		
c.	Have you ever had chest pain during exercise?		
d.	Have you ever had chest pain without engaging in exercise?		
e.	Do you tire more quickly than your friends during exercise?		
f.	Have you ever been diagnosed with high blood pressure?		
g.	Have you ever been told you have a heart murmur?		
h.	Have you ever had racing of your heart or skipped beats?		
i.	Has anyone in your family died suddenly before age 40?		
j.	Do you or anyone in your family have Marfan's Syndrome?		

18.)	Injury History – Fractures, strains/sprains, dislocated, etc	YES	NO	If Yes, Date/Injury
a.	Hand/wrist			
b.	Forearm/Elbow			
c.	Shoulder/Arm			
d.	Chest			
e.	Neck			
f.	Back			
g.	Hip/Thigh			
h.	Knee			
i.	Lower Leg/Ankle			
j.	Foot			

19.) Do you have any skin problems? Yes No If yes, list: _____

20.) Have you ever had a concussion? Yes No

If yes, dates and total number of diagnosed concussions: _____

21.) Have you ever had any other type of head injury? Yes No

If yes, date/injury: _____

22.) Have you ever been hospitalized for a head injury? Yes No If yes, date: _____

23.) Have you ever had a seizure? Yes No If yes, date/cause: _____

24.) Have you ever had a stringer or a burner? Yes No If yes, date: _____

25.) Are you missing one of a paired set of organs (eyes, kidneys, ovaries, testes, etc.)? Yes No

If yes, explain: _____

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26.) Do you use any special braces or pads? (ankles brace, insoles, sleeves, cane, etc.)

Yes No

If yes, what/why? _____

27.) Do you use any special appliances? (insulin pump, hearing aids, etc.)

Yes No

If yes, what: _____

28.) Do you use an inhaler?

Yes No

29.) Do you have any other chronic diseases? (Autoimmune, Lyme, Crohn's, etc.)

Yes No

If yes, list: _____

30.) Do you wear corrective lenses for sports?

Yes No

If yes, please list type (contacts, goggles, etc.): _____

31.) Do you have any other problems with your eyes or vision?

Yes No

If yes, explain: _____

32.) When was your last tetanus shot?

Date: _____

33.) Do you suffer from.....

a. Anxiety? Yes No

b. Depression? Yes No

c. Any other mental health issues? Yes No

d. If yes to any, do you want/need additional resources to deal with these issues? Yes No

e. Please explain any medications or treatments you are currently taking that relate to this question:

***Disclaimer: If you are having a mental health crisis please call:**

911

988 (Suicide and Crisis Hotline)

1(800)273-8255 (Suicide Prevention Hotline)

1(724)589-2222 (Campus Police)

741741 (Crisis Text Line)

If you are not in crisis, you can also call (724)589-2754 to schedule an appointment with the Thiel College Counseling Center

34.) If applicable:

a. When was your first period? Date/Approximate Age: _____

b. When was your most recent period? Date: _____

c. Are your periods regular? Yes No

c1. If no, any known reasons: _____

d. Are you currently pregnant or suspect you might be pregnant? Yes No

d1. If yes, how far along: _____

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Past or Current Medical History (mark X if applicable and include date last treated in box to right)

Alcohol/drug dependence		Dizziness/fainting		Mononucleosis	
Allergy/hay fever		Ear and nose problem		Pregnancy	
Anemia/blood disease		Epilepsy/seizures		Psychological problem	
Anxiety		Eye Injuries		Respiratory problem	
Arthritis/joint pain		Head Aches/Migraines		Sexually transmitted disease	
Asthma		Head injury		Shortness of breath	
Back problems		Heart problems		Skin problem	
Bladder/kidney		Hemorrhoids		Strep throat	
Blood in stool		Hepatitis		Swollen glands	
Cancer/cyst/tumor		High blood pressure		Swollen joints	
Clot in veins		High cholesterol		Thyroid disease	
Constipation		Hypoglycemia		Tuberculosis	
Depression		Insomnia		Ulcer	
Diabetes (sugar)		Liver disease/jaundice		Varicose veins	
Diarrhea		Malaria		Weight problem	

Sign Here: Student Signature & Date (Parent or Guardian if under 18 years of age) _____

Print Here: Student Typed/Printed (Parent or Guardian if under 18 years of age) _____

Doctor Sign Here: Health Care Provider Signature & Date _____ Date: _____

EMERGENCY CONTACT:

Medical Attention and Hospital Authorization

In the event that a student is ill and it is deemed necessary that he/she should have medical attention and/or hospitalization, I hereby authorize the designated representative of the College to:

- Secure the service of a health care professional
- Have him/her taken to a hospital for outpatient treatment
- Have him/her admitted to a hospital for in-patient treatment, including surgery

It is understood that this authorization will be used in case of an emergency and only when delay would jeopardize the student's welfare and when I cannot be reached immediately by telephone. It is understood that I will assume all financial obligations involved that are not covered by insurance.

Name of Healthcare Provider	Healthcare Provider Address (Street, City, State, ZIP)	Phone Number
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Emergency Contacts (please list two)

Name	Address	Phone Number
Name	Address	Phone Number

Parents'/Guardians' Places of Employment (list one or two)

Relationship	Place of Employment	Business Phone
Relationship	Place of Employment	Business Phone

Sign Here: Student's Signature _____ Parent's Signature _____
 Date _____ Date _____