Name: ____ Local Phone: ________________________
Last   First   MI

COLLEGE OF WILLIAM AND MARY
STUDENT HEALTH CENTER

INTERIM HISTORY FOR RETURNING VARSITY ATHLETES

COMPLETE IN INK

The following information is vital to adequately screen and medically clear athletes for continued participation in their sport. The purpose of this form is to update each athlete's chart with significant information regarding injuries, medical conditions, symptoms of concern, and use of medication since the athlete's entrance physical exam.

Has anyone in your family developed heart problems or experienced sudden death before age 50? Yes _____ No______

If yes: Relationship to you: _____________________ Nature of problem: ____

History: In the PAST YEAR, have any of the following happened to you? (Answer all questions)

	(Y/N)	If yes, explain.	Still a problem? (Y,N)
1. Hospitalized for any reason?	_____	___________________________________	_________________
2. Surgery of any kind?	_____	___________________________________	_________________
3. Significant injury (fracture, dislocation, etc)?	_____	___________________________________	_________________
4. Other injury (sprain, strain, etc)?	_____	___________________________________	_________________
5. Recurrent back pain?	_____	___________________________________	_________________
6. Use of medication for more than 10 days? Are you currently taking any prescription or over the counter medications or pills or using an inhaler?	_____	___________________________________	_________________
7. Allergic reaction to food, medication, or stinging insects?	_____	___________________________________	_________________
8. Passed out during or after exercise?	_____	___________________________________	_________________
9. Chest pain or dizziness during or after exercise?	_____	___________________________________	_________________
10. High blood pressure and/or high cholesterol?	_____	___________________________________	_________________
11. Irregular heartbeats?	_____	___________________________________	_________________
12. Significant head injury/knocked unconscious?	_____	___________________________________	_________________
13. Seizures?	_____	___________________________________	_________________
14. Any shortness of breath with exercise? Wheezing?	_____	___________________________________	_________________
15. Chronic or recurrent cough with exercise?	_____	___________________________________	_________________

CContinued on back

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	(Y/N)	If yes, explain.	Still a problem? (Y,N)
16. Loss or decreased function of any organ?	_____	____________________	____________
17. Have you had any illness lasting a week or more such as mono or a chronic or recurring illness or infection?	_____	____________________	____________
18. Have you had any blood disorder, including sickle cell trait, anemia (low blood), unusual bleeding, etc.?	_____	____________________	____________
19. Asthma/seasonal allergies that require medical treatment?	_____	____________________	____________
20. Menstrual problems/irregularities?	_____	____________________	____________
21. Recurrent heat exhaustion?	_____	____________________	____________
22. New onset or unusual headaches?	_____	____________________	____________
23. Have you been treated or evaluated for an eating disorder?	_____	____________________	____________
24. Have you been treated, or encouraged to seek treatment for an alcohol or substance/drug abuse problem?	_____	____________________	____________
Would you like information or to speak with someone confidentially concerning these issues?	_____	____________________	
25. Any other significant illness or problems?	_____	____________________	____________

PLEASE READ AND SIGN BELOW:

(A.) I certify that the above information is accurate and complete to the best of my knowledge. I realize that falsification of the provided information is a violation of the honor code that could result in sanctioning by a hearing panel.

(B.) I give my permission for Certified Athletic Trainers (within the Athletic Department), Student Health Center Staff, and all consulting physicians, permission to exchange, written or orally, any information concerning any injuries or illness which effects my ability to participate in physical activities throughout the time in which I am an official student athlete at The College of William & Mary. Any change in this status must be made in writing by the student athlete and rendered to all parties concerned.

______________________________ Student signature

______________________________ SS#

______________________________ Printed name

______________________________ Sport

______________________________ Date

Fr. So. Jr. Sr. ______ Current School year

Revised 3/01