MUSKEGON COMMUNITY COLLEGE
STUDENT – ATHLETE HEALTH RECORD

Name_____ Date of Birth_____
Home Address _____City_____ State____ Zip_____
Home Phone_____ Cell Phone (if applicable)_____
Whom to notify in case of an emergency _____ Relationship_____
Home Phone number_____ Work_____ Cell_____

FAMILY HISTORY

Father: Age ____ Health _____ Mother: Age ___ Health _____
Brothers and Sisters: Number living_____ ages_____
If any of the above are deceased, please list who, cause of death and age of death_____

Has any blood relatives ever had:

Cancer	Yes ___No ____Who_____	Asthma or Hay Fever	Yes ___No ____Who_____
Heart Disease	Yes ___No ____Who_____	Allergies	Yes ___No ____Who_____
Diabetes	Yes ___No ____Who_____	Tuberculosis	Yes ___No ____Who_____
High Blood Pressure	Yes___No ____Who_____	Stroke	Yes ___No ____Who_____
Ulcer	Yes ___No ____Who_____	Alcoholism	Yes ___No ____Who_____
Emphysema	Yes ___No ____Who_____	Mental Illness	Yes ___No ____Who_____
Migraines	Yes ___No ____Who_____	Other	_____

PERSONAL HISTORY

Any allergies to medications? Yes ___ No _____ If yes, what?_____
Any other allergies? _____
Are you taking any medication now? Yes_____ No_____ What? _____

Do you now, or have you ever in the past, had any of the following:

Migraine headaches	Yes____ No ____	Colon or Bowel trouble	Yes_____ No ____
Epilepsy or Convulsions	Yes____ No ____	Rectal trouble	Yes_____ No ____
Blindness Either Eye	Yes____ No ____	Hemorrhoids	Yes_____ No ____
Ear Infections	Yes____ No ____	Serious diarrhea	Yes_____ No ____
Deafness	Yes____ No ____	Kidney or bladder infection	Yes_____ No ____
Asthma	Yes____ No ____	Kidney stones	Yes_____ No ____
Hay Fever	Yes____ No ____	Anemia	Yes_____ No ____
Chronic Bronchitis	Yes____ No ____	Poor blood clotting	Yes_____ No ____
Emphysema	Yes____ No ____	Diabetes	Yes_____ No ____
Tuberculosis	Yes____ No ____	On insulin	Yes_____ No ____
Abnormal chest x-ray	Yes____ No ____	Gout	Yes_____ No ____
Heart Murmur	Yes____ No ____	Overactive thyroid	Yes_____ No ____
Enlarged Heart	Yes____ No ____	Underactive thyroid	Yes_____ No ____
Heart Attack	Yes____ No ____	Broken bones	Yes_____ No ____
Ulcer	Yes____ No ____	Arthritis	Yes_____ No ____
Angina	Yes____ No ____	STD(s)	Yes_____ No ____
High Blood Pressure	Yes____ No ____	Skin disease	Yes_____ No ____
Hepatitis	Yes____ No ____	Varicose Veins	Yes_____ No ____
Gall stones	Yes____ No ____	Have you lost weight recently?	Yes_____ No ____
Cirrhosis of Liver	Yes____ No ____	Do you have difficulty sleeping?	Yes_____ No ____

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SYSTEM REVIEW

Do You Have Any of the Following Complaints, Problems, or Concerns?

GENERAL

Fever	Yes ____	No ____
Chills	Yes ____	No ____
General Weakness	Yes ____	No ____
Memory Loss	Yes ____	No ____
Swollen Glands	Yes ____	No ____
Easy Bruising	Yes ____	No ____

HEAD

Blurred Vision	Yes ____	No ____
Double Vision	Yes ____	No ____
Light Flashes	Yes ____	No ____
Halos Around Lights	Yes ____	No ____
Pain in Your Eyes	Yes ____	No ____
Ear Pain	Yes ____	No ____
Drainage from Ear	Yes ____	No ____
Hearing Difficulty	Yes ____	No ____
Buzzing/Ringing of Ears	Yes ____	No ____
Nosebleeds	Yes ____	No ____
Sinus Trouble	Yes ____	No ____
Difficulty Swallowing	Yes ____	No ____
Mouth, Teeth Problems	Yes ____	No ____
Persistent Hoarseness	Yes ____	No ____
Severe Headaches	Yes ____	No ____
Other _____		

SKIN

Changing Moles	Yes ____	No ____
Rash	Yes ____	No ____
Yellow Skin	Yes ____	No ____
Other _____		

NECK

Swelling	Yes ____	No ____
Lumps	Yes ____	No ____
Stiffness	Yes ____	No ____
Other _____		

CHEST, HEART, LUNGS

Shortness of Breath	Yes ____	No ____
Frequent Cough	Yes ____	No ____
Fluttering of Heart	Yes ____	No ____
Unusual Heartbeat	Yes ____	No ____
Chest Pain or Pressure	Yes ____	No ____
Coughing up Blood	Yes ____	No ____
Wheezing	Yes ____	No ____

WOMEN

Menstrual Difficulties	Yes ____	No ____
Breast disease	Yes ____	No ____
Number of Times Pregnant	Yes ____	No ____
Number of Miscarriages	Yes ____	No ____

GASTROINTESTINAL

Poor Appetite	Yes_____	No ____
Indigestion/Heartburn	Yes_____	No ____
Difficulty Swallowing	Yes_____	No ____
Nausea or Vomiting	Yes_____	No ____
Vomiting Blood	Yes_____	No ____
Abdominal Pain or Cramps	Yes_____	No ____
Abdominal Swelling	Yes_____	No ____
Diarrhea	Yes_____	No ____
Constipation	Yes_____	No ____
Change in Bowel Habits	Yes_____	No ____
Pass Blood from Rectum	Yes_____	No ____
Black, Tar-like Bowel Movements	Yes ____	No ____
Other	Yes_____	No ____

KIDNEY

Blood in Urine	Yes_____	No ____
Pain or Burning when Urinating	Yes_____	No ____
Difficulty Passing Urine	Yes_____	No ____
Difficulty Controlling Urine	Yes_____	No ____
Getting Up at Night to Urinate	Yes_____	No ____

NEUROMUSCULAR

Weakness in Arms or Legs	Yes_____	No ____
Difficulty with Balance	Yes_____	No ____
Dizzy Spells	Yes_____	No ____
Fainting Spells	Yes_____	No ____
Speech difficulty	Yes_____	No ____

PSYCHOLOGIC

Do You Find Your Life:

Generally Unsatisfactory	Yes_____	No ____
Too Demanding	Yes_____	No ____
Boring	Yes_____	No ____
Satisfactory	Yes_____	No ____

Do You Worry About:

Money	Yes_____	No ____
Job	Yes_____	No ____
Marriage	Yes_____	No ____
Home Life	Yes_____	No ____
Children	Yes_____	No ____

Do You:

Cry Easily	Yes_____	No ____
Feel Inferior to Others	Yes_____	No ____
Feel Shy	Yes_____	No ____
Feel Things Often Go Wrong	Yes_____	No ____
Often Feel Depressed	Yes_____	No ____
Have Irrational Fears	Yes_____	No ____
Feel Anxious or Upset	Yes_____	No ____

Have You:

Seriously Considered Suicide	Yes _____	No ____
Attempted Suicide	Yes_____	No ____

DATE FORM COMPLETED_____ **SIGNATURE** _____