

Clayton State
Department of Athletics
Student-Athlete Medical History

Name: _____

Sport: _____

Student-Athlete's Family Medical History:

**Please indicate if any of the following is present in any member of your family. If so, state which family member (s) were affected. **

Diabetes _____ Hypertension _____ Blood Disease _____ Heat _____ Cancer _____ Sickle Cell _____

Explain: _____

Student-Athlete's Medical History: (please check either "yes" or "no" to the following. Answer fully.)

Head, Neck, and Back

Have you ever had a seizure, convulsions, or epileptic attack? Yes No

Have you ever had a concussion or been unconscious? Yes No

Have you ever had any serious dental or mouth injuries? Yes No

Have you ever injured your back? Yes No

Have you ever had surgery on your head, neck and/or back? Yes No

Are you currently under the care of a physician for your head, neck and/ or back? Yes No

If "yes" to any of the above, please explain: _____

Foot and Ankle

Have you ever had an ankle, foot, or Achilles tendon injury? Yes No

Have you ever had surgery on your foot, ankle and/or Achilles tendon? Yes No

Are you currently under the care of a physician for your foot or ankle? Yes No

If "yes" to any of the above, please explain: _____

Eyes, Ears, and Nose

Do you wear glasses or contact lenses? Yes No

Do you have a hearing impairment? Yes No

Have you ever had surgery on your eyes, ears, and/or nose? Yes No

Have you ever had surgery on your eyes, ears, and/or nose? Yes No

If "yes" to any of the above, please explain: _____

Knee

Have you ever had a significant knee injury? Yes No

Have you ever had surgery on your knee? Yes No

Are you currently under the care of a physician for your knee? Yes No

If "yes" to any of the above, please explain: _____

