To the Student:
This information is strictly for the use of the Health Center and will not be revealed to anyone without your knowledge and consent.

Gable Health and Counseling Center/Department of Sports Medicine

13th & Bern Streets, P.O. Box 15234 • Reading, PA 19612-5234
(610) 921-7532 • FAX (610) 921-7590

REPORT OF MEDICAL HISTORY

PLEASE COMPLETE THIS BEFORE GOING TO YOUR PHYSICIAN FOR EXAMINATION

Sex: M ☐ F ☐

Last Name First Name Middle Date of Birth Class Entering Marital Status

Home Address City State Zip Code Cell Phone Number Home Telephone Number

Mother/Guardian: Name Address City State Zip Code Cell Phone Number Home Telephone Number

Father/Guardian: Name Address City State Zip Code Cell Phone Number Home Telephone Number

Mother/Guardian Employer and Phone Number: Father/Guardian Employer and Phone Number

Transfer Students: List names and addresses of colleges you have attended.

Will you be participating in Albright Athletics: _____ If so, which sports?_____

FAMILY HISTORY

	Age	State of Health	Occupation	Age of Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Have any of your relatives ever had any of the following?

	Yes	No	Relationship
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
Arthritis			
Stomach Disease			
Asthma, Hay Fever			
Epilepsy, Convulsions			

PERSONAL HISTORY (**Please answer all questions.** Comment on all positive answers in space below or on separate sheet.)

HAVE YOU HAD?	Yes	No
Scarlet Fever		
Chicken Pox		
Malaria		
Sinusitis		
Recurrent Colds		
Chronic Cough		
Dental Problems		
Eye trouble		
Ear, Nose, or Throat trouble		
Shortness of Breath		
Orthopedic Surgeries		
Surgery		
Appendectomy		
Tonsillectomy		
Hernia Repair		
Other:		

	Yes	No
Insomnia		
Frequent Anxiety		
Worry or Nervousness		
Depression		
Recurrent Headache		
Head Injury		
Hay Fever, Asthma		
ADD/Hyperactivity Disorder		
Tuberculosis		
Allergy		
Penicillin		
Sulfonamides		
Serum		
Foods (which)		
Other:		

	Yes	No
Pain/Pressure in Chest		
Palpitations (Heart)		
High or Low Blood Pressure		
Rheumatic Fever or Heart Murmur		
Injury of Joints		
Sickle Cell Disease/Trait		
Rheumatologic Diseases		
Back Problems		
Tumor, Cancer, Cyst		
Jaundice		
Stomach or Intestinal trouble		

	Yes	No
Gallbladder trouble or Gallstones		
Recurrent Diarrhea		
Hernia		
Recent Gain or Loss of Weight		
Dizziness, Fainting		
Weakness, Paralysis		
Sexually Transmitted Infection		
Albumin/Sugar in Urine		
Frequent Urination		
FEMALES ONLY		
Currently Pregnant?		
Irregular Periods		
Severe Cramps		
Excessive Flow		

	Yes	No
A. Has your physical activity been restricted during the past five years? (give reasons and durations)		
B. Have you had difficulty with school, studies or teachers? (give details)		
C. Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? (give details)		
D. Have you had any illness or injury or been hospitalized other than already noted? (give details)		
E. Have you consulted or been treated by clinics, physicians, healers or other practitioners within the past five years? (other than checkups)		
F. Have you been rejected for or discharged from military service because of physical, emotional or other reasons? (if so, give details)		
G. Concussion History? Date of Concussion(s) If so, how many? How long did you miss your sport?		
H. Is there loss or serious impaired function of any paired organ?		

USE ADDITIONAL SHEET FOR REMARKS OR ADDITIONAL INFORMATION

I understand that any special physical condition or circumstance that may arise may necessitate the infirmary personnel to share confidential information with local medical personnel to insure appropriate medical care.

_____
Student's Signature

_____ _____
Physician's Signature (acknowledging review) Date

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TO THE HEALTH CARE PROVIDER: Please review the student's history and complete the provider's report. Please comment on all positive answers. This student has been accepted. The information supplied will not affect his/her status. It will be used only as a background for providing health and mental health care. Physical Exam must be done within 1 year prior to college entrance.

LAST NAME (Print) _____FIRST NAME_____ DOB:____/____/____ SEX: M F

BP_____/_____P _____ Height _____ Weight _____

VISUAL ACUITY: R _____/_____ L _____/_____ Corrected: Y N

Current Medications and Dosage: _____

_____

	Normal	Abnormal – Please Describe
Skin		
Head and Scalp		
Eyes		
Ears/Hearing		
Mouth, Nose, Throat		
Neck		
Heart		
Lungs		
Abdomen / Hernia		
Genitourinary		
Metabolic/Endocrine		
Musculoskeletal		
Neurologic		
Emotional		

☐ **CLEARED** for full activity _____(list sport)
☐ **CLEARED**, with recommendation(s) for further evaluation or treatment for:_____
☐ **NOT CLEARED** for the following types of sports (please check those that apply):
☐ COLLISION ☐ CONTACT ☐ NON-CONTACT ☐ STRENUOUS ☐ MODERATELY STRENUOUS ☐ NON-STRENUOUS

Is the patient currently under treatment for any medical or psychological condition? Yes _____ No _____

If yes, please explain:

_____

Do you have any recommendations regarding the care of this student, not previously addressed? Yes _____ No _____
If yes, please explain:

_____

Health Care Provider Signature _____**Health Care Provider Name (printed)** _____

Address:

_____

Provider Telephone Number: _____ Fax Number: _____ Date _____