

# George Mason University

## CLUB SPORT MEDICAL AND PHYSICAL HISTORY FORM

Club Member/Parent should complete **Page 1** only. The physician should complete **Pages 2 and 3**.

Date \_\_\_\_\_ Club \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

All information is confidential and is retained exclusively for the use of The George Mason University Department of Intercollegiate Athletics and Recreation.

Name	Date of Birth:
Social Security No.	Student I.D. (if different from SSN)
<b>PERMANENT ADDRESS</b>	
Street:	City:
State:	Zip:
	Home Phone:

Do you have an absence or loss of function in any of the following body parts?						
Eye	Ear	Lung	Internal Organ	Genital Organ	Kidney	Other
Explain:						

**Please check Y Yes or No and provide appropriate dates and explanations for all items listed below:**

Prior occurrence of exertional chest pain/discomfort?	Y	N	Explain:
Prior occurrence of fainting/dizziness?	Y	N	Explain:
Unexplained/unexpected shortness of breath or fatigue with exercise?	Y	N	Explain:
Heart murmur?	Y	N	
High or low blood pressure?	Y	N	Explain:
Frequent headaches?	Y	N	Explain:
Family history of sudden death?	Y	N	Younger than 50 years? Y N
Family history of heart disease?	Y	N	Younger than 50 years? Y N
History of Rheumatic Fever?	Y	N	Explain:
Personal or Family history of diabetes?	Y	N	Explain:
Weight change of 5 lbs. Or more?	Y	N	Explain:
History of irregular menstrual cycle?	Y	N	
Heat Exhaustion?	Y	N	When:
Concussion or other head and/or neck injury? When:	Y	N	Explain:
Surgery or serious illness? When:	Y	N	Explain:
Shoulder injury? When:	Y	N	Explain:
Elbow, wrist, or hand injury? When:	Y	N	Explain:
Back and/or hip injury? When:	Y	N	Explain:
Knee injury? When:	Y	N	Explain:
Lower leg, ankle, and/or foot injury? When:	Y	N	Explain:
Other injury? When:	Y	N	Explain:
Do you wear corrective lenses?	Y	N	Contacts? Y N
Are you now under a doctor's care?	Y	N	If yes, for what condition?
Do you have asthma?	Y	N	Please list medications:
Do you use an inhaler?	Y	N	
Please list all medications you are currently taking:			
Please list all supplements (including vitamins) you are currently taking:			
Please list all allergies (medications, food, pollen, other):			

**DATE:** \_\_\_\_\_