

Medical History Lock Haven University

Name: _____ Sport(s): _____ Date: ____/____/____

Age: _____ Date of Birth: ____/____/____ Social Security #: _____ - _____ - _____

Semester expecting to 1st arrive at LHU: _____ Circle One: Freshman Transfer

Parent / Guardian Names: _____

Home Address: _____ Phone: (____) _____
Street

_____ Phone: (____) _____
City State Zip code

Emergency Contact: _____ Phone: (____) _____

Do you, or have you ever had?	YES	NO	Family History	Do you, or have you ever had?	YES	NO	Family History
Allergies				Vision Problems			
Food/Bee Stings				Concussion			
Drugs/Medications				Hernia			
Asthma				Diabetes			
Inhaler - Type				Epilepsy/Convulsions			
Heart Trouble/Murmur				Mononucleosis			
Pain/Pressure in Chest				Anemia			
Heart Palpitation				Absence of Paired Organ			
High/Low Blood Pressure				-Kidney, Testicle, etc...			
Shortness of Breath				Absence of Menstrual Period			
Dizziness				Irregular Period			
Heat Illness				Hepatitis			
Fainting with Exercise				HIV			
Frequent Headaches				Tuberculosis			

If you have answered yes to any of the medical history categories, please provide additional information as requested or as you feel necessary.

Do you have any other medical problems or conditions the LHU medical staff should be aware of?

Have you ever been hospitalized for any illness or required surgery of any nature? If so, please explain.

Please list any medications you take regularly. Please include pain killers and birth control.

List All Injuries: Please include dates and extent of injuries	
Back	
Knee	
Ankle	
Hip	
Shoulder	
Elbow	
Wrist	
Head/Neck	

**Insurance Information
-Please Complete All Information-**

Primary Physician: _____ Phone: (____) _____

Physician's Address: _____
Street

City State Zip code

Primary Insurance: _____

Address: _____ Phone: (____) _____
Street

City State Zip code

Agreement/Policy #: _____ Group: _____ Plan: _____

Name of Insured: _____ Social Security #: _____ - _____ - _____

Birth Date: ____/____/____ If HMO, pre-certification phone number: (____) _____

Member Services Phone Number: (____) _____

Secondary Insurance: _____

Address: _____ Phone: (____) _____
Street

City State Zip code

Agreement/Policy #: _____ Group: _____ Plan: _____

Name of Insured: _____ Social Security #: _____ - _____ - _____

Birth Date: ____/____/____ If HMO, pre-certification phone number: (____) _____

Member Services Phone Number: (____) _____

The information I have provided is accurate to the best of my knowledge. Furthermore, I hereby authorize the release of my medical information to the Athletic Training Education Program at Lock Haven University. I understand that this information will be kept confidential among the members of the Athletic Training Education Program.

 Athlete's Signature

____/____/____
 Date