

Medical History Update Lock Haven University

The purpose of this form is to update the lock Haven University sports medicine staff on any changes in your medical history that may warrant further attention. Please be thorough in the information you provide.

Name: _____ Sport: _____ Date: ____/____/____

Local Address: _____

Local Phone: (____) _____

Home Address: _____ Phone: (____) _____

Street

City

State

Zip code

Emergency Contact: _____ Phone: (____) _____

Have you developed...?	YES	NO	Family History	Have you developed...?	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			

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 ____/____/____

Lock Haven University Training Staff Only:

- _____ Okay to Participate
- _____ In need of Pre-participation Physical

Athletic Trainer's Signature Date ____/____/____