

# Vanderbilt University Camp/Clinic Medical Forms

\*Entire Page to Be Completed By Patient

## Personal History

Name	Male / Female Sex	Age	Date of Birth
School	Name of Camp Attending		
Parent/Guardian Name	Cell Phone	Work/Home Phone	
Secondary Contact Name	Relationship	Cell Phone	Work/Home Phone
Personal Physician Name	Physician Phone Number		
Insurance Company Name	Policy Number	Group Number	Phone

## Medical History

Please explain "Yes" answers below questions.

	Yes	No
1. Have you ever been hospitalized? If yes, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had surgery? If yes, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you presently taking any medications or pills? If yes, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have allergies (medicine, bees or other stinging insects, Shellfish, nuts)? If yes, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you every passed out during exercise? If yes, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been dizzy during or after exercise? If yes, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had chest pain during exercise? If yes, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had high blood pressure? If yes, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever been told that you have a heart murmur? If yes, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
10. Has anyone in your family died of heart problems or a sudden death before the age of 50? If yes, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had a head injury? If yes, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever been knocked unconscious? If yes, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever had a seizure? If yes, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever had a stinger, burner or pinched nerve? If yes, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever had heat or muscle cramps? If yes, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever been dizzy or passed out in the heat? If yes, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>

- 17. Do you have trouble breathing or do you cough during or after activities?    
If yes, explain: \_\_\_\_\_
- 18. Do you wear glasses or contacts or protective eye wear?    
If yes, explain: \_\_\_\_\_
- 19. Have you ever had any other medical problem (infectious mononucleosis, diabetes)?    
If yes, explain: \_\_\_\_\_
- 20. Have you ever had a medical problem since your last evaluation?    
If yes, explain: \_\_\_\_\_
- 21. When was your last tetanus shot? \_\_\_\_\_

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

\_\_\_\_\_  
Signature of Athlete

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date