



Medical History Form

Date: ____/____/____

Student's name: _____
(last) (first) (middle) (preferred name)

Date of birth: ____/____/____ Age: ____ Race: ____ Sex at birth: M / F
(month) (day) (year)

Social Security No: ____/____/____ Student ID: _____

Local address (apartment, dorm, etc.): _____
(street)

(state) (city) (zipcode)

Cell phone: ____ - ____ - ____ Home phone: ____ - ____ - ____

E-mail address: _____

Section in band: ☐ Brass
☐ Color guard
☐ Drum major
☐ Maroonettes
☐ Twirlers
☐ Percussion
☐ Woodwinds

Year in school: ☐ 1st year on campus
☐ 2nd year on campus
☐ 3rd year on campus
☐ 4th year on campus
☐ Other: _____

Instrument: _____

Emergency Contact 1:

Name: _____ Relationship to student: _____

Cell phone: ____ - ____ - ____ Home phone: ____ - ____ - ____

Emergency Contact 2:

Name: _____ Relationship to student: _____

Cell phone: ____ - ____ - ____ Home phone: ____ - ____ - ____

Name of Primary Care Physician: _____

Address _____
(street) (state) (city) (zipcode)

Business phone: ____ - ____ - ____

Name: _____

Date: _____

Family Medical History: Is there a history of any of the following in your immediate family?

Yes	No	Alcoholism/Drug Abuse
Yes	No	AIDS or HIV
Yes	No	Cancer
Yes	No	Diabetes
Yes	No	Epilepsy/Seizure Disorder
Yes	No	Heart Conditions
Yes	No	Hypertension
Yes	No	Hypotension
Yes	No	Mental Illness
Yes	No	Sickle Cell Trait/Disease
Yes	No	Stroke
Yes	No	Sudden death before age 50
Yes	No	Thyroid Disease

Personal Medical History: Do you have any of the following medical conditions?

Yes	No	Alcoholism/Drug Abuse
Yes	No	AIDS or HIV
Yes	No	Anemia
Yes	No	Asthma or Exercise-Induced Asthma (EIA)
Yes	No	Cancer
Yes	No	Diabetes
Yes	No	Epilepsy/Seizure Disorder
Yes	No	Frequent Headaches or Migraines
Yes	No	Heart Condition (please provide diagnosis below)
Yes	No	Hypertension
Yes	No	Hypoglycemia
Yes	No	Hypotension
Yes	No	Mental Illness (please provide diagnosis below)
Yes	No	Sickle Cell Trait/Disease
Yes	No	Thyroid Disease

Please list **ALL** medical conditions (including any checked above): _____

Do you have any emergency medications (i.e. glucagon, Epi-Pen, inhaler)? Yes No

If yes, please list: _____

If yes, do you keep your emergency medication with you? Yes No

Name: _____

Date: _____

Please list any FOOD allergies: _____

Please list any ENVIRONMENTAL allergies: _____

Please list any MEDICATION allergies: _____

Please list any medications you are currently taking: _____

Please list any supplements, vitamins, or minerals you are currently taking: _____

Please list any hospitalizations or surgeries from within the past 5 years: _____

Have you ever had an organ removed? Yes No

Please list: _____

Have you ever had trouble with heat intolerance? Yes No

If yes, when was the most recent episode of heat intolerance? _____

Were you cleared by a medical professional to return to activity? Yes No

Name: _____

Date: _____

Orthopedic History: have you ever fractured or dislocated the following body parts?

Yes	No	Hand	Fracture	Dislocation	Date:
Yes	No	Wrist	Fracture	Dislocation	Date:
Yes	No	Fingers	Fracture	Dislocation	Date:
Yes	No	Arm	Fracture	Dislocation	Date:
Yes	No	Shoulder	Fracture	Dislocation	Date:
Yes	No	Clavicle (collar bone)	Fracture	Dislocation	Date:
Yes	No	Neck	Fracture	Dislocation	Date:
Yes	No	Skull	Fracture	Dislocation	Date:
Yes	No	Rib	Fracture	Dislocation	Date:
Yes	No	Vertebrae	Fracture	Dislocation	Date:
Yes	No	Sacrum	Fracture	Dislocation	Date:
Yes	No	Coccyx (tail bone)	Fracture	Dislocation	Date:
Yes	No	Femur	Fracture	Dislocation	Date:
Yes	No	Leg	Fracture	Dislocation	Date:
Yes	No	Ankle	Fracture	Dislocation	Date:
Yes	No	Foot	Fracture	Dislocation	Date:
Yes	No	Toes	Fracture	Dislocation	Date:

Please list any orthopedic surgeries you have had: _____

Have you ever been diagnosed with a spinal defect? Yes No

If yes, please list diagnosis: _____

Have you ever had a neck or spine injury? Yes No

If yes, please provide date(s) of neck/spine injury: _____

Were you transported to the hospital for the neck/spine injury? Yes No

Did you have an x-ray, CT, or MRI scan for neck/spine injury? Yes No

Did you have numbness, burning, or stinging in your arms or legs? Yes No

Did you complete physical or occupational therapy? Yes No

Were you cleared by a physician to return to activity? Yes No

Have you ever had a concussion? Yes No

If yes, how many? _____ Date of most recent concussion: _____

Did you lose consciousness with your concussion(s)? Yes No

How long were you restricted from activity? _____

How long did your symptoms last after your most recent concussion? _____

Did you have any memory problems because of your concussion(s)? Yes No

Were you cleared by a medical professional to return to activity? Yes No

Name: _____

Date: _____

In the last 12 months, have you had any of the following tests performed for a heart condition?

- ☐ Electrocardiogram (EKG)
- ☐ Echocardiogram
- ☐ Treadmill Stress Test

If yes, for what condition were you tested? _____

In the last 12 months, have you been diagnosed with or treated for any of the following?

- | | |
|---|--|
| ☐ Chicken Pox | ☐ Polio |
| ☐ Covid | ☐ Rheumatic Fever |
| ☐ Diphtheria | ☐ Scarlet Fever |
| ☐ Hepatitis | ☐ Small Pox |
| ☐ Lyme Disease | ☐ STD/STI |
| ☐ Malaria | ☐ Tuberculosis |
| ☐ Mononucleosis | ☐ Typhoid Fever |
| ☐ Mumps | ☐ Whooping Cough |
| ☐ Pneumonia | |
| ☐ Other infectious virus (please specify): _____ | |

Do you use any of the following?

- ☐ Chewing Tobacco
- ☐ Snuff
- ☐ Smokeless Tobacco
- ☐ Cigarettes
- ☐ Cigars
- ☐ Pipe
- ☐ Vape
- ☐ Other: _____

Do you wear glasses or contact lenses? Yes No

Do you wear any dental appliances? Yes No

Do you have any implants? Yes No

Please list: _____

Do you wear any external hardware (i.e. insulin pump, hearing aid) Yes No

Please list: _____

Name: _____

Date: _____

For females only:

Do you have regular menstrual cycles? Yes No

Date of last menstrual cycle: ____/____/____

Do you have any of the following?

- ☐ Absence of menstruation
- ☐ Decreased bone density
- ☐ Endometriosis
- ☐ Ovarian cysts
- ☐ Painful menstruation

Do you take birth control? Yes No

If yes, please specify which type (pill, IUD, implant, etc.): _____

Have you ever been pregnant? Yes No

If yes, please provide date(s) of pregnancy: _____

If yes, list how many births and provide dates of births: _____

Name: _____

Date: _____

Mental Health Screening:

Have you ever been diagnosed with mental illness? Yes No

Please list any mental health diagnoses: _____

Do you currently take any medications for a mental illness? Yes No

Patient Health Questionnaire-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Total: _____

Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total: _____

Printed name: _____ Date: _____
(last) (first) (middle)

Signature of parent/guardian: _____ Date: _____
(Not required if student is 18 years or older)