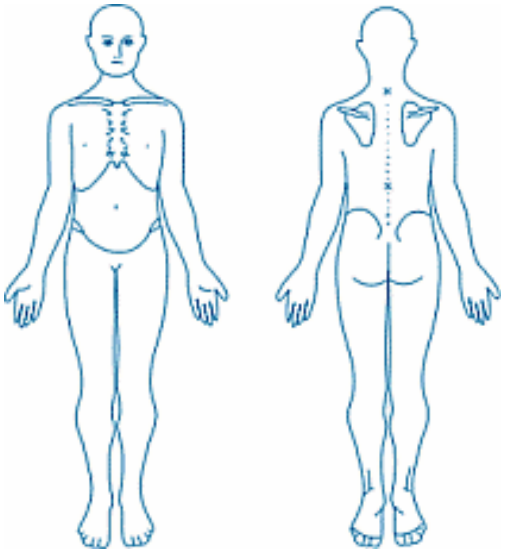
Merced College Sports Medicine
3600 M Street, Merced, CA 95340
www.mccd.edu/sportmed
(209)384-6264; fax (209) 382-6372

# MEDICAL HISTORY QUESTIONAIRE

Name_____Age_____Gender_____Date of Birth____/____/_____
Address_____Phone_____
Height_____Weight_____Personal Physician_____Physician Phone_____



Explain each marked area:

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

Signature of Student/Athlete_____Date____/____/____

Signature of Parent/Guardian (if athlete is under 18)_____Date____/____/____

All medical information is confidential and will be used by authorized medical staff and trustees of the system, which include: Team Physician, Staff Athletic Trainers, Student Athletic Trainers, Staff Nurse, Division Dean, Athletic Director, Conference Commissioner, Athletics Secretary, Head Coach, Team Assistant Coaches, and Equipment Manager. The medical information or disclosed will be specific to your current injury or overall health status. Only the minimum necessary information will be released to accomplish the intended purpose.

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