CENTER FOR HEALTH SCIENCES-ATHLETIC TRAINING PROGRAM

Medical Health History Worksheet (PAGE 1)

Today's Date: ______/______/______

Name: (Last)____________________ (First) ___________________ (Middle) __________________ Last 4 digits SS#:_______

Home Address: ______________________City: ________________State: ______Zip: _________Phone#: (____)________________

Date of Birth: ____/____/______ Place of Birth (city & state): ___________________________ Age: _________ Sex: M F

Mother's/Guardian's Name: ________________________________ Work Phone #: (____)__________________

Father's/Guardian's Name: ________________________________ Work Phone #: (____)__________________

Contact in case of Emergency (preferably a local non-relative):

Name: ________________________ Home Phone #: (____)________________ Work Phone #: (____)_______________

* *

Have any of your blood relatives ever had:

Condition	Yes	No	Maternal or Paternal
Sudden Death (before age 55)			
Diabetes			
Epilepsy			
Heart Disease			
Hemophilia			
Blood Disorders (sickle cell, leukemia)			
High blood pressure			
Mental Disorders			
Stroke			
Tuberculosis			
Drug and/or Alcohol dependency			

Immunization Record: **You must provide a copy of your shot record along with this form.**

Last known Immunizations	Who gave it	City/State	Date(s) of Injection
Tetanus/Diptheria			
Measles, Mumps, and Rubella (MMR)			
Hepatitis B shot Series			
Tuberculosis Skin titre test			
Influenza (Flu)			

Allergies:

Substance	Yes	No	Substance	Yes	No
Aspirin			Insect Bites/Stings		
Codeine			Tetanus Antitoxin/Serums		
Cortisone			Nail Polish/Cosmetics		
Sulfa			Any foods:		
Anti-inflammatories			Any other drug:		
Penicillin			Other:		
Hay Fever			Other:		

Medical Health History Worksheet (PAGE 2)

Do you CURRENTLY have any of the following symptoms or problems?

Condition	Yes	No	Condition	Yes	No
Frequent headaches			Abdominal pain		
Visual changes			Muscle cramps		
Ringing in ears			Frequent nausea		
Sore throats			Frequent vomiting		
Sinus congestion			Frequent diarrhea		
Breathing difficulty			Rectal bleeding		
Recurring coughing			Unusual fatigue		
Chest pain			Trouble sleeping		

Dental:

Question	Yes	No
Do you have a bridge or false teeth?		
Have you ever fractured a tooth?		
Have you had a tooth knocked out?		
Do you wear a mouth protector?		
Do you wear orthodontic appliances?		

Please provide us with the name and phone number of your current dentist

Name: _____

Phone #: ( )_____

Usage of Drugs, Food Supplements, and Miscellaneous Agents:

Agent	Never	Rarely	Occasionally	Frequently
Vitamins				
Diet Pills				
Sleeping Pills				
Laxatives				
Alcoholic Beverages				
Antihistamines				
Anti-inflammatoires				
Caffeine				
Tobacco				
Other:				

Internal:

1. Were you born with a complete set of paired organs? (eyes, ears, kidneys, ovaries/testicles, lungs) ☐ Yes ☐ No
2. If not, which organs were involved: _____
3. Have you ever had surgery to repair or remove any organ(s)? (hernia, tonsils, appendix, spleen) ☐ Yes ☐ No
4. If yes, which organ(s)? _____ Date of surgery? _____/_____/_____

Circle YES or NO for ALL questions listed and **explain any "yes" answers** in the space provided at the bottom of this page.

General Medical Data

Have you ever been advised by a medical doctor not to participate in physical activity? For what reasons? _____ YES NO

Are you under a physician's care for any reason now or have you been under a physician's care in the past 12 months? YES NO

Have you ever been hospitalized? YES NO

Have you ever had surgery? If yes, what? _____ YES NO

Are you currently on prescribed medication or drugs? If so, what? _____ YES NO

Have you ever had heat or muscle cramps? YES NO

Have you ever been dizzy or passed out in the heat? YES NO

Have you had any other medical problem? If yes, what? _____ YES NO

Disease and Illness

Have you ever been treated for, or informed by a medical doctor that you have had, rheumatic fever? If so, when? _____ YES NO

Have you ever experienced an epileptic seizure or been informed that you might have epilepsy? YES NO

Have you ever been treated for diabetes? YES NO

Have you ever passed out during or after exercise? YES NO

Have you ever been dizzy during or after exercise? YES NO

Have you ever had chest pain during or after exercise? YES NO

Have you ever had high blood pressure? YES NO

Have you ever been told you have a heart murmur? YES NO

Have you ever had racing of your heart or skipped beats? YES NO

Do you have or have you had skin rashes in the last six months? YES NO

If needed, use to explain any "YES" answers…

_____

_____

Head and Neck Injuries

Do you wear contacts? YES NO

Have you been "knocked out" or experienced a concussion during the past three years? YES NO
If yes, when _____

If you answered "yes" to the above, have you been "knocked out" more than once? Give dates. _____ YES NO

If you answered "yes" to the above, did you stay overnight in a hospital? YES NO

Have you ever had a stinger or burner or pinched nerve? If yes, when _____ YES NO

Musculoskeletal

Have you ever had a fracture? If yes, where & when? _____ YES NO

Have you ever had an injury to…

your shoulder? L or R YES NO
if yes, when _____
your elbow? L or R YES NO
if yes, when _____
your knee? L or R YES NO
if yes, when _____
your ankle? L or R YES NO
if yes, when _____
your foot? L or R YES NO
if yes, when _____

Have any of the above injuries ever caused you to miss more than one week's activity? If so, which injury(s)? _____ YES NO

Have you ever been advised to have surgery to correct any of the above injuries? If so, which injury(s)? _____ YES NO

Have you ever had an injury to your back? YES NO
If yes, when _____
Do you experience frequent pain in the back? YES NO

Have you seen a physician or chiropractor for back pain? If yes, when? _____ YES NO

If needed, use to explain any "YES" answers…

_____

_____

Center for Health Sciences-Athletic Training Program

PHYSICAL EXAM

PLEASE PRINT DATE OF EXAM: _____/_____/_____

Last Name _____First Name_____ Date of Birth _____/_____/_____

Height _____ Weight _____ Pulse _____ BP _____ / _____ (_____ / _____ / _____)
Re-check BP (if necessary)

Current Medications: _____ Allergies: _____

Vision: R 20 / _____ L 20 / _____ Corrected: Y N Pupils: Equal _____ Unequal _____

Medical	Normal	Abnormal Findings
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (male only)		
Skin		

Musculoskeletal		
Neck		
Back		
Shoulder / Arm		
Elbow / Forearm		
Wrist / Hand		
Hip / Thigh		
Knee		
Leg / Ankle		
Foot		

CLEARANCE
( ) Cleared

( ) Cleared after re-evaluation for: _____

( ) Not cleared for Reason: _____

Recommendations: _____

Name of Examiner: _____ Credentials (please circle one): MD DO PA

Address of practice:_____ Phone Number:_____

Signature of Examiner _____ Date _____/_____/_____