



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:

Table with 4 columns: Condition, Yes, No, Maternal or Paternal. Rows include 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.

Table with 4 columns: Last known Immunizations, Who gave it, City/State, Date(s) of Injection. Rows include Tetanus/Diphtheria, Measles, Mumps, and Rubella (MMR), Hepatitis B shot Series, Tuberculosis Skin titre test, Influenza (Flu).

Allergies:

Table with 6 columns: Substance, Yes, No, Substance, Yes, No. Rows include Aspirin, Codeine, Cortisone, Sulfa, Anti-inflammatories, Penicillin, Hay Fever, Insect Bites/Stings, Tetanus Antitoxin/Serums, Nail Polish/Cosmetics, Any foods, Any other drug, Other, Other.



Medical Health History Worksheet (PAGE 2)

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

Table with 6 columns: Condition, Yes, No, Condition, Yes, No. Rows include: Frequent headaches, Visual changes, Ringing in ears, Sore throats, Sinus congestion, Breathing difficulty, Recurring coughing, Chest pain, Abdominal pain, Muscle cramps, Frequent nausea, Frequent vomiting, Frequent diarrhea, Rectal bleeding, Unusual fatigue, Trouble sleeping.

Dental:

Table with 4 columns: Question, Yes, No. Rows include: 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:

Table with 5 columns: Agent, Never, Rarely, Occasionally, Frequently. Rows include: 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)
2. If not, which organs were involved:
3. Have you ever had surgery to repair or remove any organ(s)? (hernia, tonsils, appendix, spleen)
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? If yes, when

If you answered "yes" to the above, have you been "knocked out" more than once? Give dates.

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

Musculoskeletal

Have you ever had a fracture? If yes, where & when?

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)?

Have you ever been advised to have surgery to correct any of the above injuries? If so, which injury(s)?

Have you ever had an injury to your back? 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? 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 | Normal | Abnormal Findings |
|-----------------|--------|-------------------|
| 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 ____/____/____