Section A

CONFIDENTIAL MEDICAL HISTORY

To Be Completed By Student

Name: _____ Date of Birth: _____

PLEASE CIRCLE ◯ ALL THAT APPLY AND INCLUDE DATES AS NEEDED:

None / Negative medical history

Cancer:_____

Cardiovascular:
Anemia
Blood Clotting Disorder
Congenital Heart Defects
Dizzy or fainting spells
Heart Condition/Murmur
High/Low Blood Pressure
Phlebitis (Blood Clot)
Sickle Cell Disease/Trait

Endocrine:
Diabetes (Type 1 or 2)
Thyroid disease

EENT (eye, ear, nose, throat):
Ear Infections
Eye Injury/Vision Loss

Mononucleosis
Seasonal Allergies
Sinusitis
Tonsillitis
Tonsillectomy & Adenoidectomy

GI/Abdominal:
Appendectomy
Blood in stool
Crohn's Disease
Diarrhea (chronic)
Hepatitis A/B/C
Hernia
IBS
Liver/splenic injury
Parasitic Infection
Ulcer / GERD
Ulcerative Colitis

Musculoskeletal:
Back Pain
Bone Fracture
Ligament Injuries
Severe sprains

Neurological:
Concussion
Head Injury
Impact Testing ☐ NO ☐ YES
Migraines/severe headaches
Seizure disorder

Psychological:
Counseling ☐ NO ☐ YES
ADD/ADHD
Anxiety
Autism Spectrum Disorder
Bipolar
Depression
Eating Disorder
OCD

Respiratory:
Anaphylaxis (severe allergic reaction)
Asthma- Well controlled? ☐ NO ☐ YES
Bronchitis/ Pneumonia
Tuberculosis

Skin:
Acne
Eczema
Hives
Psoriasis

Urology:
Blood/Protein in Urine
Kidney Stones
Loss of Kidney
Nephritis (Kidney Infection)
Urinary Tract Infection

Other illnesses/surgeries or hospitalizations: _____

Have you had Chicken Pox ☐ NO ☐ YES Date of Disease required: _____

ALLERGIES: (food, insect, medication) _____

Do the allergies listed above require the use of an Epi Pen? ☐ NO ☐ YES

CURRENT MEDICATIONS: (including birth control pills & vitamins) _____

Any cultural/religious/gender considerations we should be aware of? ☐ NO ☐ YES _____

HEALTH BEHAVIORS	No	Yes
a. Do you Smoke or Vape?		
b. Do you chew tobacco?		
c. Do you have a history of alcohol or drug misuse?		
d. Do you worry too much about your weight or have any unhealthy weight control issues?		
e. Do you exercise regularly? (150 minutes a week is recommended)		
f. Do you eat a well-balanced diet? (this should include at least 5-7 fruits and vegetables per day)		
g. If sexually active, do you use condoms?		

BIOLOGICAL FAMILY HISTORY

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

PHYSICAL EXAMINATION

To Be Completed By Health Care Provider within one (1) year prior to college start date

Student Name: _____ (Last) _____ (First) _____ (Middle) Date of Exam: _____

Height: _____ Weight: _____ BMI: _____ Blood Pressure: _____ Visual Acuity: (R) _____ (L) _____ (corrected/uncorrected)

Has the patient experienced any of the following during or immediately after exercising?

Fainting	☐ YES	☐ NO	Unusual Fatigue	☐ YES	☐ NO	Dizzy or light headed	☐ YES	☐ NO
Chest Pain	☐ YES	☐ NO	Heart Racing	☐ YES	☐ NO	Shortness of breath	☐ YES	☐ NO
Hives	☐ YES	☐ NO						

Has any blood relative had any of the following conditions: (including parents, siblings, grandparents, aunts, uncles. Explain below.)

Early death (Give age and reason) _____

Heart attack/surgery (Give age) _____

Cardiomyopathy (Abnormal heart structure) _____

Marfan's Syndrome _____

Prolonged QT interval or arrhythmia _____

SYSTEM	NORMAL	ABNORMAL	EXPLANATION OF ABNORMAL FINDINGS
1. Skin			
2. Ears			
3. Eyes			
4. Nose, throat, teeth			
5. Neck, thyroid			
6. Chest, breasts			
7. Lungs			
8. Heart			
9. Abdomen, kidneys			
10. Genitalia			
11. Pelvic (if indicated)			
12. Rectal (if indicated)			
13. Lymphatic			
14. Extremities, back, spine			
15. Neurological			
16. Psychological			

Additional Comments: _____

SPORTS CLEARANCE:

Based on review of Medical H/P is this student able to participate in sports without restriction? (circle one) **YES** **NO**

ALLERGY HISTORY

Does this student have any allergies (food, insect, medication)? (circle one) **YES** **NO**

Please list allergies _____

Do the allergies listed above require the use of epinephrine? (circle one) **YES** **NO**

If yes, has an epi-pen and instruction for use been provided to the student? (circle one) **YES** **NO**

I have reviewed this student's medical history:

Provider Name: _____ Phone: _____

Address: _____

Signature: _____ Date: _____