Waldorf University
Student Medical History

This form includes your family, personal, and sports related medical history. It is important information that helps the athletic/student health staff provides quality medical care. This information is confidential and will not be released to any unauthorized personnel. Use additional paper if necessary.

Full Name______________________________ Sport: ______________ Date of Birth______________
(Last) (First) (MI)

Family Health History- Please answer as thoroughly as possible.

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Sister					
Sister					
Brother					
Brother					

Has a member of your family been treated for:

	Y	N	Relationship
Arthritis			
Diabetes			
Epilepsy, Seizures			
Heart Disease			
Kidney Disease			
Sickle Cell Disease			
Stomach Complications			
Tuberculosis			

Personal Medical History- Read carefully, answer Yes or No for all items listed.

	Y	N		Y	N		Y	N
Alcohol, Tobacco, Drug Addiction			Heat Illness/Heat Exhaustion/Heat Stroke			Use of Performance Enhancing Supplements		
Allergies			Hernia (Femoral, Inguinal, 'Sports', Other)			Creatine		
Food(s):			Loss of Paired Organ Function (eye, kidney, etc)			Ephedrine		
Drug(s):			Malaria			Steroids		
Seasonal:			Migraine Headaches			Other:		
Bee Sting:			Mononucleosis			Vision Problems		
Other:			Recurrent Colds/Cough			Glasses and / or contacts		
Asthma			Recurrent Diarrhea			Weight Fluctuations		
Bronchitis/Pneumonia/Tuberculosis			Recurrent Headaches			Cardiovascular Screening:		
Cancer / Tumor / Cyst			Rheumatic Fever/Heart Murmur			During or after exercise have you ever:		
Chronic Skin Disease			Scarlet Fever			Excessive fatigue with exercise?		
Depression / Anxiety			Sexually Transmitted Disease			Had a rash or hives develop?		
Diabetes			Sickle Cell Disease/Trait			Fainted or felt dizzy?		
Ear / Nose / Throat Problems			Speech/Hearing Problem			Had chest pain?		
Epilepsy / Seizures			Stomach/Intestinal Illness			Had shortness of breath?		
Fainting			Surgery			Had racing heart or skipped heartbeats?		
Females Only			Appendectomy			Do you tire more easily than your friends?		
Irregular periods			Hernia Repair			Become ill from exercising in the heat?		
Severe cramps			Orthopedic			Wheeze, cough, or have trouble breathing?		
Excessive flow			Tonsillectomy			Have you ever had an echocardiogram ?		
Medications prescribed:			Other:			Do you have a heart murmur?		
			Thyroid/Endocrine Disturbance			Personal or family history of Marfan's Syndrome		

Explain "yes" answers here:

Have you ever sustained an injury to any of the following? Please supply approximate date of injury, and time lost with your explanation.

PAST INJURIES	Y	N	Explain:
Concussion / Loss of Consciousness			
Neck (Pinched nerves, 'stingers')			
Back (Surgery - back spasms)			
Chest/Abdomen/Hip (Spleen rupture, fractured rib)			
Shoulder (Dislocation, separation, fracture, surgery)			
Elbow (Surgery)			
Forearm/Wrist/Hand (Surgery, fracture, cartilage tear)			
Knee (Surgery, ligament sprain, cartilage tear)			
Ankle/Foot (Surgery, fracture, sprain)			
Do you currently wear a special brace to perform in your sport?			
Have you ever been in a motor vehicle accident?			
Have you ever been hospitalized at any time?			

List ALL medications you currently use:

I hereby state that to the best of my knowledge, my answers to the above questions are complete and correct. I understand that any previous injuries or illness not revealed at the time of this medical history would release Waldorf from any financial responsibilities for such injuries or illness.

Signature of the Student-Athlete: ______________________________ Date: ______________

Signature of Parent/Legal Guardian: ______________________________ Date: ______________
(If student is under age of 18)

Waldorf University
PHYSICAL EXAMINATION FORM

Full Name____ Date: ____________________ Date of Birth____________________
(Last) (First) (MI)

Height________ Weight________ Body Fat %________ Pulse________ BP ______/______ (Seated) ______/______ (Supine) ______/______ (Standing) (If elevated)
(Optional)

Vision R 20/_______ L 20/_______ w/Correction: Y N Eye Protection: Y N Mouth guard: Y N

Lab results if indicated: ____

HEENT		NOTES
Ears	Nrl / Abnrl	
Mouth	Nrl / Abnrl	
Throat	Nrl / Abnrl	
Dental	Nrl / Abnrl	
Thyroid	Nrl / Abnrl	
Lymph nodes	Nrl / Abnrl	
Lungs	Nrl / Abnrl	
Cardiovascular	Nrl / Abnrl	
Abdomen	Nrl / Abnrl	
Genitalia	Nrl / Abnrl	
Hernia	N / Y	
Skin	Nrl / Abnrl	
MUSCULOSKELETAL		
Neck	Nrl / Abnrl	
Back	Nrl / Abnrl	
Shoulder / Arm	Nrl / Abnrl	
Elbow / Forearm	Nrl / Abnrl	
Wrist / Hand / Fingers	Nrl / Abnrl	
Hip / Thigh	Nrl / Abnrl	
Knee	Nrl / Abnrl	
Leg / Ankle	Nrl / Abnrl	
Foot / Toes	Nrl / Abnrl	

COMMENTS AND RECOMMENDATIONS:

Cleared: ____

Cleared after completing evaluation / rehabilitation for: ________________________

Not Cleared: ____

Reason not cleared: ____

a. Is the patient now under treatment for any medical condition? Yes ________ No________

Diagnosis: ____

b. Is the patient now under treatment for any emotional condition? Yes________ No________

Diagnosis: ____

Recommendations: ____

____

Examining Physician (Print/Type): ________________________________ Date: ____________

Address: ____ Phone: ____________

Signature of Examining Physician: ____