MTSU ATHLETIC TRAINING EDUCATION PROGRAM

MEDICAL HISTORY & PHYSICAL EXAMINATION

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_/\_\_\_\_/\_\_\_\_\_ Race:\_\_\_\_\_\_\_\_ Sex:\_\_\_\_\_\_

Medical History: Answer all of the following questions by marking the appropriate box. Explain any yes answers below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| # | YES | NO | IF YES is checked, use the space below to explain |  |
| 1. |  |  | Are you currently under a doctor’s care? If so, who? Why? |  |
| 2. |  |  | Do you have any chronic or recurrent illnesses? (diabetes, asthma, ulcer, bronchitis, sickle cell anemia) |  |
| 3. |  |  | Have you been hospitalized for any reason? |  |
| 4. |  |  | Have you had any illnesses/conditions requiring bed rest of 1 week or longer? |  |
| 5. |  |  | Have you had any surgery? |  |
| 6. |  |  | Have you been advised to have any surgery, but chosen not to have it? |  |
| 7. |  |  | Are you presently taking any medications? |  |
| 8. |  |  | Are you allergic to any medications? (aspirin, penicillin) |  |
| 9. |  |  | Are you allergic to any food or insect? |  |
| 10. |  |  | Have you ever had any of the following symptoms of heart problems? |  |
|  |  |  | Chest pain |  |
|  |  |  | High blood pressure |  |
|  |  |  | Close relative under 40 to die of heart disease |  |
|  |  |  | Heart racing |  |
|  |  |  | Mitral valve prolapse |  |
| 11. |  |  | Have you had any dizziness, fainting, convulsions, or frequent headaches? |  |
| 12. |  |  | Have you ever been knocked out or had a concussion? If so, how many times? |  |
| 13. |  |  | Do you wear eyeglasses contact lenses? |  |
| 14. |  |  | Have you had any serious eye injuries? |  |
| 15. |  |  | Do you wear any dental appliances? |  |
| 16. |  |  | Have you ever suffered from heat exhaustion or heat stroke? |  |
| 17. |  |  | Has your weight changed by 10lbs or more within the last 6 months? |  |
| 18. |  |  | Are you presently taking creatine? How long? |  |
| 19. |  |  | Have you ever had mononucleosis? If so, what month and year. |  |
| 20. |  |  | Do you have any history of an enlarged spleen or liver? |  |
| 21. |  |  | Do you have any organ missing other than tonsils? |  |
| 22. |  |  | Do you have any history of a collapsed lung or tuberculosis? |  |
| 23. |  |  | Have you ever been told that you had sickle cell disease or trait? |  |
| 24. |  |  | Have you had a knee injury? |  |
| 25. |  |  | Have you had an injury to your feet? |  |
| 26. |  |  | Have you injured your ankle? |  |
| 27. |  |  | Have you had a neck injury? |  |
| 28. |  |  | Do you have any hearing impairments? |  |
| 29. |  |  | Have you had any low back injury? |  |
| 30. |  |  | Have you had any other joint sprains or dislocations? |  |
| 31. |  |  | Have you had any broken bones? |  |
| 32. |  |  | Do you have a history of stress fractures? |  |
| 33. |  |  | Do you know of any reason that you should not participate? |  |

DESCRIBE ANY “YES” RESPONSE IN DETAIL IN THE SPACE PROVIDED BELOW, ENTER THE QUESTION # BEFORE EACH COMMENT.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

All statements answered in this record are true to the best of my knowledge. I have no abnormality, limitations or restrictions not mentioned in this record. I understand that this information is used to help determine my fitness to participate in the athletic training program.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Normal | Irregular | Place “x”in appropriate column | Describe every abnormality in detail |
|  |  | 1. HEENT |  |
|  |  | 1. NECK |  |
|  |  | 1. CHEST |  |
|  |  | 1. CV |  |
|  |  | 1. ABDOMINAL |  |
|  |  | 1. GU |  |
|  |  | 1. HERNIA |  |
|  |  | 1. NEURO |  |
|  |  | 1. SKIN |  |

**This athlete (MAY) or (MAY NOT) participate in the athletic training education program based on the data gathered from this examination.**

**Physician signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, M.D. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I (provider), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(print), verify that the above candidate for the athletic training education program has received all the required immunizations as shown below.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(signature)**

**Immunizations**

|  |  |  |
| --- | --- | --- |
|  | **Date** | **Clinic/Provider** |
| **DTP** |  |  |
| **DTP** |  |  |
| **DTP** |  |  |
| **DTP** |  |  |
| **DTP** |  |  |
| **HEP B** |  |  |
| **HEP B** |  |  |
| **HEP B** |  |  |
| **HIB** |  |  |
| **HIB** |  |  |
| **HIB** |  |  |
| **HIB** |  |  |
| **POLIO** |  |  |
| **POLIO** |  |  |
| **POLIO** |  |  |
| **POLIO** |  |  |
| **MMR** |  |  |
| **MMR** |  |  |