

# Waldorf College

## 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 provide quality medical care. Please take your time and complete this form thoroughly and accurately. This information is confidential and will not be released to any unauthorized personnel. Use additional paper if necessary.

Full Name \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) Sport: \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Family Health History-** Please answer as thoroughly as possible.

Has a member of your family been treated for:

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

	Y	N	Relationship
Arthritis			
Diabetes Mellitus			
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			Weight Fluctuations		
Bronchitis/Pneumonia/Tuberculosis			Recurrent Diarrhea					
Cancer/Tumor/Cyst			Recurrent Headaches			Cardiovascular Screening:		
Chronic Skin Disease			Rheumatic Fever/Heart Murmur			During or after exercise have you ever:		
Depression/Anxiety			Scarlet Fever			Excessive fatigue with exercise?		
Diabetes Mellitus			Sexually Transmitted Disease			Had a rash or hives develop?		
Ear/Nose/Throat Problems			Sickle Cell Disease/Trait			Fainted or felt dizzy?		
Epilepsy/Seizures			Speech/Hearing Problem			Had chest pain?		
<b>Females Only</b>			Stomach/Intestinal Illness			Had shortness of breath?		
Irregular periods			Surgery			Had racing heart or skipped heartbeats?		
Severe cramps			Appendectomy			Do you tire more easily than your friends?		
Excessive flow			Hernia Repair			Become ill from exercising in the heat?		
Medications prescribed:			Orthopedic			Wheeze, cough, or have trouble breathing?		
			Tonsillectomy			Have you ever had an echocardiogram (ECG)?		
			Other:			Do you have a heart murmur?		
			Thyroid/Endocrine Disturbance			Personal or family history of Marfan's Syndrome		
Please explain any "yes" answers:								

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

<b>PAST INJURIES</b>	Y	N	Explain:
Concussion			
Loss of Consciousness?			
Neck (Pinched nerves, 'stingers')			
Back (Surgery, 'spondy', 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?			
Please list ALL medications/drugs 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 College 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 College

## PHYSICAL EXAMINATION FORM

Full Name \_\_\_\_\_ Date: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Last) (First) (MI)

Height \_\_\_\_\_ Weight \_\_\_\_\_ Body Fat % \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Optional) (If elevated)  
Seated Supine Standing

Vision R 20/\_\_\_\_\_ L 20/\_\_\_\_\_ w/Correction: Y N Eye Protection: Y N Mouthguard: Y N

HEENT		NOTES
Anisocoria	N / Y	
Fundoscopy	Nrl / Abnrl	
Ears	Nrl / Abnrl	
Mouth	Nrl / Abnrl	
Throat	Nrl / Abnrl	
Dental	Nrl / Abnrl	
Thyroid	Nrl / Abnrl	
Lymph nodes	Nrl / Abnrl	
Lungs	Nrl / Abnrl	
Abdomen	Nrl / Abnrl	
Genitalia	Nrl / Abnrl	
Hernia	N / Y	
Skin	Nrl / Abnrl	
<b>MUSCULOSKELETAL</b>		
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	

CARDIAC SCREENING		Stigmata of Marfan's Syndrome (males > 6'0, females > 5'10)	
Heart Murmur	Nrl / Abnrl	Armspan > Height	N/Y
Grade	I II III IV V VI	Chest deformity	N/Y
Systolic ejection		Pectus excavatum	N/Y
Mid-systolic		Pectus carinatum	N/Y
Holostolic		Glasses / contact lenses	N/Y
Diastolic		"Thumb" sign	N/Y
Click		"Wrist" sign	N/Y
Valsalva	↑ ↓		
Squat	↑ ↓		
Pulses (radial / femoral)	Nrl / Abnrl		

### COMMENTS AND RECOMMENDATIONS:

Cleared: \_\_\_\_\_ Cleared after completing evaluation / rehabilitation for: \_\_\_\_\_ Not Cleared: \_\_\_\_\_

Reason not cleared: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Examining Physician (Print/Type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Examining Physician: \_\_\_\_\_