Carroll University Master of Athletic Training Program

HEALTH HISTORY AND PHYSICAL EXAM FORM

To be completed by the student and reviewed with your MD, DO, PA, or NP before starting the MSAT program and annually thereafter.

Print Name:_____DOB_____Date _____

Check and list year of illness after any of the following that you have had. Describe any complications or effects still present under remarks.

( ) Chicken Pox	( ) German Measles	( ) Infectious mononucleosis	( ) Measles
( ) Mumps	( ) Scarlet Fever	( ) Infectious hepatitis	( ) Encephalitis
( ) Meningitis	( ) Amebiasis	( ) Anemia	( ) Arthritis
( ) Kidney Disease	( ) Nervous Breakdown	( ) Intestinal Parasitic Infection	( ) Pneumonia
( ) Pleurisy	( ) Tonsillitis	( ) Venereal Disease	( ) Rheumatic Fever
( ) Diabetes	( ) Epilepsy	( ) Heart Disease	( ) Tuberculosis
			( ) Any Other Illness

Check the following conditions and complaints you have had, or are subject to at present time, and describe further under remarks.

( ) Head Injury	( ) Heart Murmur	( ) Disease or injury of	( ) Any Psychiatric
( ) Frequent Headaches	( ) Swelling of feet or	( ) Hernia	( ) Convulsions
( ) Visual Difficulty	( ) Shortness of breath	( ) Jaundice	( ) Paralysis
( ) Dizziness	( ) Asthma	( ) Chronic Diarrhea	( ) Severe Anxiety
( ) Sinus Trouble	( ) Chronic Cough	( ) Difficulty with urination	( ) Tendency to Worry
( ) Hay Fever	( ) Loss of Weight	( ) Sugar or albumin in	( ) Depression
( ) Frequent Sore Throat	( ) Digestive upsets	( ) Skin Disease	( ) Fainting Spells
( ) Abdominal Cramps	( ) Difficulty Sleeping	( ) Any unusual bleeding	( ) Frequent Colds
( ) Persistent Backache	( ) Menstrual Problems		

Remarks:

List surgical operations you have had, with dates:

List any serious accidents or injuries, with dates:

List any allergies to drugs or foods:

List medications taken at present:

Please describe your general state of health now:

Please describe any physical, mental, or emotional problems not mentioned above:

Family History:

( ) Migraine	( ) Diabetes	( ) Kidney Disease	( ) Mental Illness
( ) Blood Diseases	( ) Heart Disease	( ) Epilepsy	( ) Tuberculosis
( ) High Blood Pressure	( ) Stomach Trouble		

To the licensed healthcare provider: Please review the complete history filled in by the student and add/or complete anything of significance.

Name:_____DOB_____
(Print) (Last) (First) (Middle)

Height_____Weight_____Blood Pressure_____Pulse_____

Conditions	Normal	Abnormal	Comments
General Appearance	N	A	
Eyes, Pupils, Lids	N	A	
Fundi	N	A	
Ears	N	A	
Nose, Throat	N	A	
Teeth, Gums	N	A	
Thyroid, Neck	N	A	
Lymph Nodes	N	A	
Thorax	N	A	
Heart	N	A	
Lungs	N	A	
Abdomen, Hernia	N	A	
Back, Spine	N	A	
Extremities	N	A	
Circulation & Peripheral Pulses	N	A	
Neurological	N	A	
Skin, Lymphatic	N	A	
Lab Studies	N	A	**Attach results to form**

I certify based upon my examination that this student appears free of symptoms of illness or communicable disease that may be transmitted through normal contact.

Synopsis/Comments:

Licensed Healthcare Provider Signature

Print Name_____Date_____

Address _____

Student Signature

Print Name_____Date_____