



Medical Evaluation Form

Parts I, II, and III are to be completed by the student prior to physical examination.

Part IV is to be completed by a licensed physician with a signature required.

I. Personal Information

Name		Date	
Primary Address			
City, State, Zip			
DOB			
Home Phone			

II. Personal History

Check whether you have had any of the following conditions. If yes, provide date(s) and details in the space provided.

Yes	No		Yes	No	
		Anemia			Eating disorders
		Asthma			Gynecological disorder
		Drug or alcohol dependency			Headachees
		Depression or anxiety			Mononucleosis
		Diabetes			Physical disability
		Epilepsy or seizures			Significant injury or illness
		Head injury or concussion			Thyroid disorder
		Kidney or bladder problems			Ulcers, stomach problems
		Weight loss greater than 10 lbs.			Other

Details: _____

Do you have any allergies to:

Medications (list) _____

Food (list) _____

Environment (list) _____

Latex _____

I use /used tobacco products.

Circle all that apply: none smokeless cigars cigarettes other

In the past year, did you drink alcohol?

If yes, circle average use: <1 day/week 2-4 days/week 5-7 days/week

III. Family History

Have any of your relatives ever had any of the following?	Yes	No	Relationship
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
Stroke			
High Blood Pressure			
Arthritis			
Stomach Disease			
Asthma			
Hayfever			
Cancer (list type)			
Mental Illness/Chem. Dependency			

IV. Medical Evaluation by Health Care Provider

Male____ Female____

Height	
Weight	
Blood Pressure	
Pulse	

Nml	Abn	General Assessment	Nml	Abn	Musculoskeletal Assessment
		Head			C-spine
		Eyes			Shoulders
		ENT			Elbows
		Mouth/Teeth			Wrists
		Lungs			Hands
		Abdomen			Spine
		GU			Hips
		Skin			Knees
		Neurological			Ankles/Feet

Licensed Professional Name	
Licensed Professional Signature	
Date of Examination	
Phone Number	
Fax Number	