ATHLETIC TRAINING EDUCATION PROGRAM APPLICATION

MEDICAL HISTORY

NAME: _____
Last (Print) First Middle (Maiden)

Male _____ Female _____ DATE OF BIRTH: _____/_____/_____
Month Day Year

HOME ADDRESS: _____
Number and Street City State Zip Code

HOME TELEPHONE NUMBER: _____

FATHER'S NAME: _____ PHONE NUMBER: _____

ADDRESS: _____
Number and Street City State Zip Code

MOTHER'S NAME: _____ PHONE NUMBER: _____

ADDRESS: _____
Number and Street City State Zip Code

SPOUSE'S NAME: _____ PHONE NUMBER: _____

ADDRESS: _____
Number and Street City State Zip Code

MARITAL STATUS: SINGLE _____ MARRIED _____ DIVORCED _____

INDICATE CLASS: FRESHMAN _____ SOPHOMORE _____ JUNIOR _____ SENIOR _____

INTERNATIONAL _____ TRANSFER _____ GRADUATE _____

NUMBER OF CHILDREN: _____

ARE YOU ON A SPECIAL DIET? YES _____ NO _____

IF YES, PLEASE EXPLAIN: _____

_____

_____

_____

_____

FAMILY HISTORY

Name(s)	Age	Health	Occupation	Age at death	Cause of death
Father					
Mother					
Brothers					
Sisters					
Children					

Do you have a relative with any of the following? ANSWER YES OR NO BY CHECK MARK (√)

	Yes	No	Relationship
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
Arthritis			
Stomach Disease			
Stroke			
Epilepsy, Convulsions			
Mental Illness			
Suicide			
High Blood Pressure			
Mother or Sister w/Breast Cancer			

PERSONAL HISTORY

Please answer all questions and comment on positive answers. USE CHECK MARK (√)

HAVE YOU HAD?	Yes	Comment	No
Scarlet fever			
Measles (Rubeola)			
German Measles (Rubella)			
Mumps			
Mononucleosis			
Chicken Pox			
Malaria			
Tuberculosis			
Poliomyelitis			
Rheumatic Fever			
Hepatitis			

PERSONAL HISTORY continued

Have you ever been diagnosed with or treated for:	**Yes**	**No**
Asthma		
Diabetes		
Epilepsy		
Allergies (Specify)		
Foods (Which)		
Other		
Do you have trouble with:	**Yes**	**No**
Eyes		
Ears		
Nose		
Mouth		
Throat		
Glands		
Heart Murmur		
Lungs		
Stomach		
Kidneys/Bladder		
Back		
Muscles/Joints		
Nerves		
Have you:	**Yes**	**No**
Had Surgery		
Broken Bones		
Attempted Suicide		
Had Seizures		
*(FEMALES ONLY answer the following 3)		
Had Menstrual Problems		
Had Breast Problems		
Been Pregnant		
Do you experience frequent:	**Yes**	**No**
Headaches		
Fainting		
Trouble Sleeping		
Anxiety		
Depression		
Infections		
Urination		
Diarrhea		
Trouble Breathing		
Please Explain “Yes” Answers:		

PERSONAL HISTORY continued

List allergies to medications:

_____

List current medications and dietary supplements:

_____

_____

Has your physical activity been restricted during the past five years? Yes _____ No _____

If yes, give reasons and duration: _____

_____

Have you had any illness or injury or been hospitalized other than already noted? Yes _____ No _____

If yes, explain:

_____

_____

Have you consulted or been treated by clinics, physicians, healers, or other practitioners for any MAJOR medical or emotional problems within the past five years? Yes _____ No _____

If yes, explain:

_____

_____

Comments:

_____

_____

_____

_____

_____