# LINDENWOOD UNIVERSITY MEDICAL EXAMINATION FORM

## ATHLETIC TRAINING STUDENT INFORMATION

| Last Name | | First Name | Middle Name |
|---|---|---|---|
| Date of Birth | | Gender | Ethnicity (optional) |
| Home Address | | | |
| City | State | Country (if not U.S.) | Zip Code |
| Primary phone | | Email | |

## PERSONAL MEDICAL HISTORY

If answered yes, please describe in the space provided.

| | | |
|---|---|---|
| Have you ever been hospitalized? | ☐Yes ☐No | |
| Have you ever had surgery? | ☐Yes ☐No | |
| Do you have any know allergies? (i.e. medicines, insects, foods, etc.) | ☐Yes ☐No | |
| Are you currently taking any medications? (i.e. prescription, hormones, birth control, etc.) | ☐Yes ☐No | |
| Are you currently taking supplements? | ☐Yes ☐No | |
| Have you ever had any skin conditions? | ☐Yes ☐No | |
| Have you had any problems with your eyes or vision? (i.e. glasses, eye injury | ☐Yes ☐No | |
| Have you ever been diagnosed with asthma? | ☐Yes ☐No | |

## GENERAL MEDICAL HISTORY

Have you **OR ANYONE IN YOUR FAMILY** been diagnosed with the following?

| | | | |
|---|---|---|---|
| Diabetes | ☐Yes ☐No | Rheumatoid Arthritis | ☐Yes ☐No |
| Kidney Disorder | ☐Yes ☐No | Ulcerative Colitis/Crohn's Disease | ☐Yes ☐No |
| Depression | ☐Yes ☐No | Irritable Bowel Syndrome | ☐Yes ☐No |
| Anxiety | ☐Yes ☐No | Hyperthyroidism | ☐Yes ☐No |
| Eating Disorder | ☐Yes ☐No | Hypothyroidism | ☐Yes ☐No |
| Please Describe | | | |

## RESPIRATORY MEDICAL HISTORY

**During or after exercise**, have you ever experienced any of the following? If yes, please describe in the space provided.

| | | |
|---|---|---|
| Difficulty breathing | ☐Yes ☐No | |
| Wheezing | ☐Yes ☐No | |
| Shortness of breath | ☐Yes ☐No | |
| Chest tightness | ☐Yes ☐No | |
| Persistent cough | ☐Yes ☐No | |
| Coughing up blood | ☐Yes ☐No | |

# CARDIOVASCULAR MEDICAL HISTORY

Have you **OR ANYONE IN YOU FAMILY** been diagnosed with the following? If yes, please describe in the space provided.

| | | |
|---|---|---|
| History of heart disease | ☐Yes ☐No | |
| Marfan's Syndrome | ☐Yes ☐No | |
| Heart Defect | ☐Yes ☐No | |
| High/Low Blood Pressure | ☐Yes ☐No | |
| Pericarditis, Myocarditis, or Endocarditis | ☐Yes ☐No | |
| Anemia/Sickle Cell Anemia | ☐Yes ☐No | |
| Iron Deficiency | ☐Yes ☐No | |
| Peripheral Vascular Disease | ☐Yes ☐No | |

**During or after exercise**, have you ever experienced any of the following? If yes, please describe in the space provided.

| | | |
|---|---|---|
| Dizzy or light headed | ☐Yes ☐No | |
| Passed out or fainted | ☐Yes ☐No | |
| Chest pain or discomfort | ☐Yes ☐No | |
| Racing, irregular, or skipping heart beat | ☐Yes ☐No | |

# GENITOURINARY/REPRODUCTIVE HISTORY (FEMALE)

In the past 12 months, have you had any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Heavy menstrual bleeding | ☐Yes ☐No | Painful Menstruation | ☐Yes ☐No | Absence of Menstruation | ☐Yes ☐No |
| Bleeding between periods | ☐Yes ☐No | Menstrual cramps | ☐Yes ☐No | Genital Itching | ☐Yes ☐No |
| Irregular Periods | ☐Yes ☐No | Lumps in breasts | ☐Yes ☐No | Vaginal Discharge | ☐Yes ☐No |
| Frequent Urination | ☐Yes ☐No | Pain/Burning during urination | ☐Yes ☐No | Blood in your urine | ☐Yes ☐No |
| Please Describe | | | | | |

# GENITOURINARY/REPRODUCTIVE HISTORY (MALE)

| | | |
|---|---|---|
| Do you feel pain or burning with urination? | ☐Yes ☐No | |
| Any blood in your urine? | ☐Yes ☐No | |
| Do you have problems with frequent urination? | ☐Yes ☐No | |
| Do you have any problems emptying your bladder? | ☐Yes ☐No | |
| Have you noted any discharge from your penis? | ☐Yes ☐No | |
| Has the force of your urination decreased? | ☐Yes ☐No | |
| Have you had any kidney, bladder, or prostate issues in the last 12 months? | ☐Yes ☐No | |
| Any testicular torsion, pain, or swelling? | ☐Yes ☐No | |

## NEUROLOGICAL MEDICAL HISTORY

Do you have any of the following symptoms on a regular basis?

| | | | | | |
|---|---|---|---|---|---|
| Headaches | ☐Yes ☐No | "Pressure in the head" | ☐Yes ☐No | Blurred Vision | ☐Yes ☐No |
| Nausea | ☐Yes ☐No | Ringing in the ears | ☐Yes ☐No | Double Vision | ☐Yes ☐No |
| Dizziness | ☐Yes ☐No | Tingling in the extremities | ☐Yes ☐No | Numbness in the extremities | ☐Yes ☐No |
| Vomiting | ☐Yes ☐No | Slurred speech | ☐Yes ☐No | Difficulty sleeping | ☐Yes ☐No |
| Difficulty concentrating | ☐Yes ☐No | Irritability | ☐Yes ☐No | Sensitivity to light | ☐Yes ☐No |
| "Burner or Stinger" | ☐Yes ☐No | Migraine headaches | ☐Yes ☐No | Seizures | ☐Yes ☐No |

## MUSCULOSKELETAL HISTORY

Please indicate if you have sustained any injuries to said body parts. If yes, please describe in the space provided. Also, please note any diagnostic tests performed (i.e. x-ray, MRI).

| | | |
|---|---|---|
| Head/Neck | ☐Yes ☐No | |
| Shoulder | ☐Yes ☐No | |
| Upper Arm | ☐Yes ☐No | |
| Elbow | ☐Yes ☐No | |
| Forearm | ☐Yes ☐No | |
| Wrist/Hand | ☐Yes ☐No | |
| Chest | ☐Yes ☐No | |
| Spine | ☐Yes ☐No | |
| Abdomen | ☐Yes ☐No | |
| Pelvis/Hip | ☐Yes ☐No | |
| Thigh | ☐Yes ☐No | |
| Knee | ☐Yes ☐No | |
| Lower leg | ☐Yes ☐No | |
| Ankle | ☐Yes ☐No | |
| Foot | ☐Yes ☐No | |

# MEDICAL EXAMINATION

Must be completed by **a physician, a physician's assistant, or a nurse practitioner.**

| Blood Pressure | Pulse | Weight | Height |
|---|---|---|---|

| Body Part | Normal | Explanation of Abnormal Findings |
|---|---|---|
| **Head, scalp, face** | ☐Yes ☐No | |
| **Eyes** | ☐Yes ☐No | |
| **Ears** | ☐Yes ☐No | |
| **Nose** | ☐Yes ☐No | |
| **Mouth and Throat** | ☐Yes ☐No | |
| **Teeth** | ☐Yes ☐No | |
| **Neck** | ☐Yes ☐No | |
| **Lungs** | ☐Yes ☐No | |
| **Heart** | ☐Yes ☐No | |
| **Breasts** | ☐Yes ☐No | |
| **Abdomen** | ☐Yes ☐No | |
| **Genitalia (Pelvic if needed)** | ☐Yes ☐No | |
| **Rectal** | ☐Yes ☐No | |
| **Hernia** | ☐Yes ☐No | |
| **Adenopathy** | ☐Yes ☐No | |
| **Skin** | ☐Yes ☐No | |
| **Reflexes** | ☐Yes ☐No | |
| **Musculoskeletal Examination Findings:** | | |
| **Cleared to Fully Participate in Athletic Training Program** | ☐Yes ☐No | **Limitations/Follow-up** |

| SIGNATURE | DATE |
|---|---|
| | |