### PLEASE PRINT ALL INFORMATION

Name:			Date of Birth:	Age:	
Home Address:	or Box#		City State	Zip Code	
			Social Security #:	·	
	PE	RSONA	L MEDICAL HISTORY		
List any DRUGS or foods the	nat you a	re allergic	to: (Print "NONE" if no answer. <b>DO NOT LEAVE</b>	BLANK	<u>(!!)</u>
Please check "YES" if you	curren	tly have	or have ever had any of the conditions lis	ted.	
	YES	NO		YES	NO
High Blood Pressure Migraine Headaches			Frequent Headaches Frequent Sore Throats		
Mononucleosis			Hearing Problems		
Heart Problems			Heart Trouble		
Heart Murmur(s) Nervous Stomach			Ulcers		
Frequent Diarrhea			Appendicitis Hemorrhoids		-
Hernia			Kidney or Bladder (Infections or Stones)		
Diabetes			Epilepsy (Attacks, Seizures, or Fits)		
Pneumonia			Frequent Upper Respiratory Infection		
Hepatitis Fainting Spells			Frequent Skin Infections Dizzy Episodes		
Heat Exhaustion			Chest Pain		
Back Pain			Joint Pain		
Vision Problems			Asthma		
	<u> </u>	AMILY	MEDICAL HISTORY		
Check "YES" if anyone in	your far	nily curr	ently has or ever has had any of the cond	litions li	sted.
	YES	NO			
Diabetes			Who:		
High Blood Pressure			Who:		
Heart Disease Fainting Spells			Who:		
Blood Diseases			Who: Who:		

## **PERSONAL INJURY HISTORY**

<u>SPRAI</u>	NS: (Chronic)						
	ANKLE		None		Right	Le	eft
	KNEE				Left (inside)		
		Hyperex	ktension:		Right		Left
	ELBOW		None		Right	Le	eft
	BACK		None		Upper	Lo	ower
	NECK		No		Yes		
	SHOULDER A-C				Right		
	,,,	00	paradom		g		
DISI O	CATIONS:						
<u>DIOLO</u>	List area and nur	nber of tir	mes. Inclu	ude Left o	r Right.		
FRAC1	ΓURES: List bones and gi	ve dates.	Include l	_eft or Rig	ht.		
<u>OTHE</u>		illed mus	cles? (Plea	ase list)			
	,		`	′ =			
	2. Any medication	ns you tal	ke regular	ly? (Pleas	e list)		
	3. Do you wear?	Glasses	YES	NO	Contacts	YES	NO
	3. Do you wear?	Bridges	YES	NO	False Teeth	YES	NO

## **MEDICAL QUESTIONAIRE**

N	lame of Operation: octor:	Town & Hospital:	_ Date:		
١	lame of Operation:		_ Date:		
OTHER	MEDICAL QUESTIONS:				
1	. How many times have you b	een knocked out from any c	ause?		
	Date(s):				
2	. Have you been hospitalized	as a result of a head injury?		YES	NO
	Date(s):				
3	. Have you ever been told to	stop or give up sports for any	reason?	YES	NO
	Reason:				
4	. Has anyone in your family d	ied suddenly below the age	of 40 years?	YES	NO
	Reason:				
5	. Have you ever had serious t	rouble breathing after runnir	g or exercise?	YES	NO
	If yes, when:				
6	. What is the sickest you have	e ever been? When:			
	Reason:				
7	. Have you ever spent the nig	ht in the hospital?		YES	NC
	If yes, why:				
8	. Have you ever been tested f	for sickle cell anemia?		YES	NO
	If yes, what were the results	? Pos	tive	Neg	ative
g	. Have you ever been tested f	for sickle cell trait?		YES	NO
	If yes, what were the results	? Pos	tive	Neg	ative
10	. Has a member of your family or sickle cell trait?	y ever been diagnosed with	sickle cell anem	ia YES	NO
——— ΓΗΕ ANSV	VERS I HAVE PROVIDED AB	OVE ARE CORRECT TO TH	HE BEST OF MY	/ KNOW	/LEC
-	SIGNATURE		 DATE		



# ANGELO STATE UNIVERSITY A THLETIC DEPARTMENT

### PHYSICAL EXAMINATION

#### PHYSICAL EXAMINATION AND FORM TO BE COMPLETED BY PHYSICIAN:

HEIGHT:		WEIGH	T:	BP:	VISION:
REGION	NORMAL	ABNORMAL	DESCRIPTION & C	OMMENTS	
ENT					
LUNGS CHEST CARDIO					
ABDOMEN G.U. SYSTEM HERNIA					
NEUROLOGICAL					
SPINE					
SHOULDERS					
ELBOWS HANDS					
HIPS					
KNEES					
ANKLES					
OTHER PERTINE	NT INFORM	ATION:			
PASS: F	=AIL:	DATE:	SI	GNATURE:	HYSICIAN
PHYSICIAN'S NAI	ME PRINTE	D:			YSICIAN'S PHONE:
PHYSICIAN'S ADD	DESS.				