

DICKINSON STATE UNIVERSITY MEDICAL HISTORY/PHYSICAL FORM

Name _____ Local Phone _____
Last First Initial

Social Security Number _____ Date of Birth _____ Age _____

Sport(s) _____

- Date of Last Tetanus Shot _____
- YES NO 1. Do you have high or low blood pressure? HIGH LOW NORMAL
 - YES NO 2. Are you a diabetic?
 - YES NO 3. Have you ever had a seizure?
 - YES NO 4. Are you asthmatic?
 - YES NO 5. Do you have any allergies to food, medications, or other? List:
 - YES NO 6. Do you have heart palpitations or a heart murmur?
 - YES NO 7. Have you ever had a concussion or been knocked unconscious?
 - YES NO 8. Do you have a history of fainting or passing out during exercise?
 - YES NO 9. Do you experience chronic headaches?
 - YES NO 10. Have you ever sustained a neck injury?
 - YES NO 11. Have you ever experienced a tingling sensation in your arms, fingers, legs, toes, or any other body area?
 - YES NO 12. Do you wear athletic safety frames or lenses?
 - YES NO 13. Do you wear contacts? HARD SOFT
 - YES NO 14. Have you ever sustained a shoulder injury such as a separation, dislocation or fracture?
 - YES NO 15. Have you ever sustained an injury to your elbow, wrist, hand, or fingers?
 - YES NO 16. Have you ever sustained an injury to your back or hip?
 - YES NO 17. Have you ever had a knee injury?
 - YES NO 18. Have you ever had an ankle injury?
 - YES NO 19. Do any of the joints previously mentioned still continue to bother you?
 - YES NO 20. Have you ever had surgery to any of these previously mentioned joints?
 - YES NO 21. Have you ever sustained a broken bone?
 - YES NO 22. Did you previously or do you currently need to wear a special brace or splint?
 - YES NO 23. Do you have any bleeding, clotting, or circulatory problems?
 - YES NO 24. Do you have any other illnesses that we should be aware of?
 - YES NO 25. Have you ever had or do you have problems with any of the following organs?
(Circle organs which have caused problems) kidneys ovaries testicles eyes ears nose
heart lungs stomach liver spleen bladder intestines appendix
 - YES NO 27. Have you ever had some type of surgery on any other part of the body not
previously mentioned?
 - YES NO 28. Do you feel there are any other medical conditions that Dickinson State
University Athletic Trainers and Medical staff should be aware of that has not been
previously addressed?

Athlete Signature _____ Date _____

THIS FORM MUST BE COMPLETED AND SIGNED PRIOR TO YOUR ARRIVAL AT DSU. IF YOU ARE HAVING A PHYSICAL AT DSU, PLEASE BRING THIS FORM WITH YOU OR RETURN IT IN THE BUSINESS REPLY ENVELOPE. THE EXAMINING PHYSICIAN WILL COMPLETE THE REVERSE SIDE. DO NOT DISCARD THIS FORM!

(OVER)

Examiner's Initials

Height _____
Weight _____
BP/Pulse _____
Heart _____

Neck _____
Lymph _____
Pulmonary _____
Abdomen _____

Hernia _____
Upper Extremities _____
Lower Extremities _____

() Approved for Unrestricted Athletic Activities

() Not Approved for Athletic Activities

Recommendations/Risk Factors:

Physician's Signature

Date

Please explain all yes answers from other side (Please Print):
