REPORT OF MEDICAL HISTORY (Please print in black ink) To be completed by student

Last Name (Print) First Name Middle Name *Social Security Number

Local Address City State Zip Code Area Code/Phone Number
Date of Birth (mo/day/yr) _____ Gender Male _____ Female _____ Marital Status M__ S__ O__

Class you are entering (circle): FR SO JR SR
Sport(s):_____

Local Phone:
Cell Phone:

Email Address:

Name of person to contact in case of an emergency Relationship

Address

Area Code/Phone Number(home/Work/Cell)

The following health history is confidential, does not affect your admission status, and except in an emergency situation or by court order, will not be released without your written permission. Please attach additional sheets for any items that require fuller explanation.

A. FAMILY MEDICAL HISTORY: Has any blood relative ever had?

Cancer	**YES**	**NO**	Stroke	**YES**	**NO**	Alcoholism/Drug Abuse	**YES**	**NO**
Diabetes	**YES**	**NO**	Epilepsy/Seizures	**YES**	**NO**	Die suddenly before age 50 years	**YES**	**NO**
Heart Trouble	**YES**	**NO**	Mental Illness/Depression	**YES**	**NO**	Sickle Cell Trait/Disease	**YES**	**NO**
High Blood Pressure	**YES**	**NO**	Suicide	**YES**	**NO**	Bleeding Disorder/Blood Disease	**YES**	**NO**
Other, please explain:								

B. MEDICAL ILLNESS HISTORY: *NOTE: This information will be kept CONFIDENTIAL!!!

1. Have you ever had or do you now have any of the conditions below? If so, check yes. If not, check no.
2. If yes, put your age the condition occurred at in the appropriate box.

CHECK EACH ITEM	AGE	YES	NO	CHECK EACH ITEM	AGE	YES	NO	CHECK EACH ITEM	AGE	YES	NO
Car, Air, Motion, or Sea Sickness				Contact with Hepatitis B (HBV)				Palpitation or Pounding Heart			
Ear, Nose, or Throat Trouble				Contact with AIDS or HIV				Intestinal Trouble			
Asthma				Veneral Disease(STD's)				Stomach Trouble			
Bronchitis				Jaundice				Frequent Indigestion			
Chronic Cough				Mononucleosis				Cancer			
Tuberculosis				Chronic Frequent Colds				Tumor/ Growth/ Cyst			
Swimmer's Ear				Kidney Trouble				Skin Trouble			
Inner Ear Infection				Kidney Stones				Rheumatism			
Fever Blisters				Bloody Urine				Pain/Pressure in Chest			
Mumps				High Blood Pressure				Shortness of Breath			
Rheumatic Fever				Heart Trouble				Psychiatric Problems			
Hearing Loss				Painful Urination				Severe Head Injury			
Eye Problems				Frequent Urination				Excessive Worry			
Chicken Pox				Severe Abdominal Pain				Depression			
Hay Fever				Anoxeria/Bulimia				Hernia			
Arthritis				Hemorrhoids				Insomnia			
Goiter/Thyroid Disease				Peptic Ulcer				Concussion			
Diphtheria				Gall Bladder Trouble				Convulsions/ Fits			
Sinusitis				Appendicitis				Dizziness			
Sickle Cell Anemia				Gallstones				Paralysis			
3-Day Measles				Liver Trouble				Amnesia			
Malaria				Athletes Foot				Migraine Headaches			
Diabetes				Jock Itch				Frequent Headaches			
Pneumonia				Ringworm				Nausea/Vomiting			
Obesity				Lyme Disease				Heartburn			
Urinary Tract Infection				Herpes Virus				Gout			

C. GENERAL MEDICAL ALLERGIES: Please answer as to whether you are allergic to the following items?

Aspirin	**YES**	**NO**	Penicillin	**YES**	**NO**	Tetanus antitoxin or serums	**YES**	**NO**	Bee stings	**YES**	**NO**
Codeine	**YES**	**NO**	Erythromycin	**YES**	**NO**	Novocaine or other anesthetics	**YES**	**NO**	Fire ant bits	**YES**	**NO**

Sulfa Drugs	**YES**	**NO**	Ibuprofen	**YES**	**NO**	Hay Fever – dust/mold/pollen/grass	**YES**	**NO**	Wasps stings	**YES**	**NO**
Iodine	**YES**	**NO**	Acetaminophen	**YES**	**NO**	Oral Anti-inflamitories	**YES**	**NO**	Latex	**YES**	**NO**

1. Are you allergic to any other drug, medications, foods, plants, insects, etc. not listed above? If yes, please list those allergies here:	**YES**	**NO**
2. Have you ever had any reaction to Serum Drugs? If yes, please list the drugs and related details here:	**YES**	**NO**

D. GYNECOLOGICAL HISTORY: ***ONLY FEMALES ANSWER THIS SECTION***

CHECK YES OR NO FOR THE FOLLOWING & IF THE ANSWER IS YES, WRITE IN THE AGE AT WHICH THE CONDITION OCCURRED.

	Number	Date	Age		Yes	No	Age		Yes	No	Age
Number of Pregnancies				Last Pap Smear				Absence of Menstruation			
Number of Births				Endometriosis				Painful Menstruation			
Abnormal Pap Smears				Irregular Periods				Menstrual Cramps			

Are currently taking Birth Control Pills?	**YES**	**NO**	If yes, what type are you taking?

Please list any drugs, medicines, birth control pills, vitamins and minerals (prescription and nonprescription) you use and indicate how often you use them

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

*Provision of Social Security number is voluntary, is requested solely for administrative convenience and record keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.

E. GENERAL MEDICAL INFORMATION: (CIRCLE THE CORRECT ANSWER)

1. Do you have a Heart Disease? If yes, please list any medications taken for this condition:	**YES**	**NO**	Heart Disorder? If yes, please list any medications taken for this condition:	**YES**	**NO**	Heart Murmur? If yes, please list any medications taken for this condition:				**YES**	**NO**
2. Have you ever had one of the following tests performed for a heart condition?	Electrocardiogram (EKG)	**YES**	**NO**	Echocardiogram	**YES**	**NO**	Treadmill Stress Test			**YES**	**NO**
3. During the past year (twelve months) have you had any type of problem with tolerance to exercise? If yes, please give a brief explanation.										**YES**	**NO**
4. Do you have Hypertension (High Blood Pressure)?	**YES**	**NO**	Do you have Hypotension (Low Blood Pressure)?							**YES**	**NO**
5. Please list any and all medications you take for High or Low Blood Pressure including the names, dosages, and how often you take them:											
6. Have you Passed Out or had Fainting Spells?	**YES**	**NO**	Did this occur with exertional activities?							**YES**	**NO**
7. Have you ever had a Concussion? If yes, please list the number of times and severity of each below:										**YES**	**NO**
8. Have you ever been hospitalized for any of the concussions you sustained?										**YES**	**NO**
9. Have you ever been knocked unconscious? If yes, please list the number of times and which ones you were hospitalized for?										**YES**	**NO**
10. Have you ever had a Skull Fracture?	**YES**	**NO**	Double Vision?	**YES**	**NO**	Blurred Vision?				**YES**	**NO**
11. Are you a Diabetic or ever been treated for Diabetes? If yes, please list the age at which your diabetes began as well as any and all medications you take for this condition:										**YES**	**NO**
12. Do you or have you ever had Anemia?	**YES**	**NO**	Sickle- cell anemia or trait?	**YES**	**NO**	Hypoglycemia (Low Blood Sugar)?				**YES**	**NO**
13. Do you have a vision defect in either one or both eyes and if yes, please specify below:										**YES**	**NO**
14. Do you wear glasses?	**YES**	**NO**	Do you wear contact lenses?							**YES**	**NO**
15. If yes, do you wear them during practice?	**YES**	**NO**	If yes, do you wear them during games?							**YES**	**NO**
16. Have you ever had glaucoma?	**YES**	**NO**	Have you ever had retinal detachment?							**YES**	**NO**
17. Do you have a hearing defect? If yes, please specify below and list any hearing aids worn:										**YES**	**NO**
18. Do you wear any dental appliances?	**YES**	**NO**	If so, do you wear them during practice?							**YES**	**NO**
19. If yes, circle the appropriate appliance: Corrective Braces. Permanent Bridge, Permanent Crown or Jacket, Removable Partial or Full Plate											
20. Do you have any severe tooth trouble, gum trouble, or dead teeth? If yes, please list details below:										**YES**	**NO**

21. In the past 3 years have you had a Tetanus shot?	YES	NO	Toxoid shot?			YES	NO	Booster shot?							YES	NO
22. Have you ever received the Hepatitis B (HBV) Vaccination?				YES	NO	If yes, have you received all three shots?									YES	NO
23. In the past 12 months have you been treated for >>>	Mononucleosis ?			YES	NO	Pneumonia?		YES	NO	Infectious Virus?					YES	NO
24. Do you currently take any medicines or drugs? If yes, what medications or drugs are you taking, and for what reason?															YES	NO
25. Have you ever had trouble with dehydration? (Excess loss of salt & water)								YES	NO	Heat Intolerance?					YES	NO
26. Have you ever had Heat Cramps?	YES	NO	Heat Exhaustion?			YES	NO	Heat Stroke?							YES	NO
27. Have you ever suffered from or been diagnosed with Exercise Induced Asthma (EAI)? If yes, what medication(s) are you taking to control EIA?															YES	NO
28. Have you ever had an internal injury? If yes, describe the nature of the injury and the body part(s) or organ(s) involved?															YES	NO
29. Have you ever lost the full use of the following organs, either temporarily or permanently? (Hearing, Sight, Kidneys, Lungs, Testicles(male), Ovaries(female), other) If yes, please list the organ(s) and details regarding the loss, including the dates and treating physicians for each:															YES	NO
30. Have you ever had surgery to repair or remove any organ? If yes, please list the organ(s) and details regarding the repair and/or removal including the dates and treating physicians for each:															YES	NO
31. Are you an Epileptic or ever have had an Epileptic seizure ? if yes, please list any and all medications you take for this condition:															YES	NO
32. Do you have a Hernia? If yes, where?															YES	NO
33. Have you had either a gain or loss of greater than ten (10) pounds in the past 12 months?															YES	NO
34. Do you currently have any body piercing(s)?	YES	NO	If so, where?								Do you have a tattoo?				YES	NO

F. NUTRITION, DRUGS, FOOD SUPPLEMENTS, AND MISCELLANEOUS AGENTS:

Check the appropriate space according to your use of the following products:

	NEVER	RARELY	OCCASIONALLY	FREQUENTLY
Stimulants (Benzedrine, Amphetamines, etc.)				
Chewing Tobacco, Snuff, or Smokeless Tobacco				
Cigarettes, Cigars, or Pipe				
Vitamins				
Sleeping Pills				
Diet Pills				
Alcoholic Beverages				
Anabolic Steroids (growth stimulants)				
Androstenedione				
Amino Acids				
Creatine phosphate				
Antihistamines				
Ephedrine				
Any other diet, nutritional or performance enhancing drug				

G. EATING DISORDERS:

1. Have you ever had a problem with food bingeing? If yes, when?	YES	NO
2. Has it ever been suggested or have you ever been diagnosed as being anorexic? If yes, when?	YES	NO
3. Have you ever been diagnosed as bulimic or having bulimia? If yes, when?	YES	NO
4. Do you sometimes or often induce vomiting after eating?	YES	NO
5. Have you or do you take laxatives to prevent being overweight?	YES	NO

ORTHOPAEDIC MEDICAL HISTORY:

H. FRACTURES:

1. Have you ever broken (fractured) a bone? If yes, please fill in the appropriate boxes below:	YES	NO

BODY PART	DATES	BODY PART	RIGHT	LEFT	DATES
SKULL		COLLAR BONE			
NOSE		UPPER ARM			
FACE		FOREARM			
JAW		WRIST			
NECK		HAND			
SPINE		THIGH			

PELVIS		LOWER LEG			
RIBS		FOOT			

FINGERS	R_____	1_____, 2_____, 3_____, 4_____, 5_____	L_____	1_____, 2_____, 3_____, 4_____, 5_____
TOES	R_____	1_____, 2_____, 3_____, 4_____, 5_____	L_____	1_____, 2_____, 3_____, 4_____, 5_____

2. Did the fracture require surgery or create any residual defect? If yes, please describe the defect or type of surgery, date, physician, and location of the hospital.	**YES**	**NO**
3. Have you ever had a calcium deposit form in your thigh or anywhere else following a bad bruise? If yes, where is the calcium deposit located?	**YES**	**NO**
4. Have you ever had a bone spur develop and if so, where?	**YES**	**NO**

I. DISLOCATIONS:

1. Have you ever dislocated a joint? If yes, please fill out the appropriate boxes on the chart below:	**YES**	**NO**

	RIGHT	**LEFT**	**# OF TIMES**	**DATES**		**RIGHT**	**LEFT**	**# OF TIMES**	**DATES**
SHOULDER					ELBOW				
A-C JOINT					WRIST				
KNEE CAP					HIP				
KNEE					FINGERS				
NECK					TOES				
ANKLE									

2. Have you ever had surgery for a dislocation? If yes, describe surgery type, date, physician, and location of hospital below

J. MUSCLE INJURIES:

1. Have you ever had a severe muscle pull or strain?	**YES**	**NO**
2. Has this injury reoccurred? If yes, list the muscle(s) involved and date(s):	**YES**	**NO**

K. NECK:

1. Have you ever sustained a serious neck or cervical injury?					**YES**	**NO**
2. Did you have numbness, burning, or sharp pain in your arms or legs?					**YES**	**NO**
3. Have you ever had an injury producing weakness or numbness of your arms or legs or both?					**YES**	**NO**
4. Were you ever transported by ambulance for a neck injury?	**YES**	**NO**	If yes, did you have neck or spinal X-Rays taken?		**YES**	**NO**
5. Have you ever had neck surgery? If yes, describe surgery type, date, physician, and location of hospital below:					**YES**	**NO**
6. Have you ever had a burner or stinger (stretched or pinched nerve)?					**YES**	**NO**
7. Do you currently have any weakness due to a neck or spinal injury? If yes, give the location(s) of the weakness.					**YES**	**NO**

L. SPINE:

1. Have you ever injured your back? If yes, how many times? Please provide details regarding each injury including dates, treatment, rehabilitation, etc.	**YES**	**NO**
2. Were you ever diagnosed with a spinal defect of any type? If yes, provide details of defect?	**YES**	**NO**
3. Have you ever had back surgery? If yes, describe surgery type, date, physician, and location of hospital below.	**YES**	**NO**

M. SHOULDERS:

1. Have you ever had a significant shoulder joint injury?	L	R	**YES**	**NO**
2. Have you ever had an A-C sprain or separation?	L	R	**YES**	**NO**
3. Has your shoulder ever felt like it was unstable or slipping?	L	R	**YES**	**NO**
4. Have you ever had a problem with your shoulder repeatedly coming out of place?	L	R	**YES**	**NO**
5. Do you have any problems with your shoulder when trying to throw?	L	R	**YES**	**NO**
6. Do you have any problems with your shoulder with overhead activities?	L	R	**YES**	**NO**
7. Have you ever had shoulder surgery? If yes, describe surgery type, date, physician, and the location of hospital below.	L	R	**YES**	**NO**

N. ELBOW, WRIST, HAND, FINGER:

1.	Have you ever had an elbow injury or problem?	L	R	**YES**	**NO**
2.	Have you ever had a wrist injury or problem?	L	R	**YES**	**NO**
3.	Have you ever had a problem with hand or finger injury?	L	R	**YES**	**NO**
4.	Do you have a finger deformity as a result of this injury? If so, which finger?	L	R	**YES**	**NO**
5.	Have you ever had elbow, wrist, or hand/finger surgery? If yes, describe surgery type, date, physician, and the location of hospital below.			**YES**	**NO**

O. KNEES:

1.	Have you ever had a significant knee injury? If yes, please describe the injury(s) you have sustained?	L	R	**YES**	**NO**
	If you have had a significant knee injury or knee surgery, answer the following questions: A. Were you placed on a rehabilitation program?			**YES**	**NO**
	B. Do you wear any type of preventative/protective brace when you practice or play?			**YES**	**NO**
2.	Does your knee ever swell or collect fluid?	L	R	**YES**	**NO**
3.	Did you have surgery for your knee injury(s)?	L	R	**YES**	**NO**
	If yes, please describe the surgery type, date, physician, and the location of the hospital where surgery was performed				
4.	Have you had surgery on either knee more than once?	L	R	**YES**	**NO**
5.	Have you ever suffered from patellar tendinitis or jumper's knee?	L	R	**YES**	**NO**
6.	Have you ever been diagnosed with Osgood-Schlatter's disease?	L	R	**YES**	**NO**

P. ANKLES:

1.	Have you ever sustained a severe ankle sprain?	L	R	**YES**	**NO**
2.	Have you ever sustained a "high ankle sprain" or syndesmosis sprain?	L	R	**YES**	**NO**
3.	Have you ever had surgery on your ankle(s)? If yes, describe the surgery type, date, physician, and location of the hospital below.	L	R	**YES**	**NO**

Q. FEET AND TOES:

1.	Have you ever had a problem with bunions?	L	R	**YES**	**NO**
2.	Have you ever had a problem with turf toe or sprained great toe?	L	R	**YES**	**NO**
3.	Have you ever had a problem with ingrown toenails?	L	R	**YES**	**NO**

R. OTHER:

If you have any additional conditions, problems, or comments that have not been addressed thoroughly in the above questionnaire, please use the space below to inform us so that we may be able to better serve you with our best medical care.

_____

_____

IMPORTANT INFORMATION . . . PLEASE READ AND COMPLETE

STATEMENT BY STUDENT (OR PARENT/GUARDIAN, IF STUDENT IS UNDER AGE 18)

(A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

(B) I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the physicians of the Student Health Service. (Not applicable to community colleges)

(C) I am aware that the Student Health Service charges for some services and I may be billed through the College Business Office if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the Business Office and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the College is unaffected by the existence of insurance coverage. (Not applicable to community colleges)

_____ _____

Signature of Student Date

_____ _____

Signature of Parent/Guardian, if student under age 18 Date

PHYSICAL EXAMINATION

(Please print in black ink)

*To be completed and **signed** by physician or clinic*

A physical examination is required by **Chowan College.** This form must be completed in black ink and signed by a physician or clinic.

Last Name First Name Middle Name	Date of Birth (mo/day/year)	*Social Security Number
Permanent Address City State Zip Code		Area Code/Phone Number

Height _____ Weight _____ TPR _____/_____/_____ BP _____/_____

IF REQUIRED:
Vision:
Corrected Right 20/_____ Left 20/_____
Uncorrected Right 20/_____ Left 20/_____
Color Vision _____

Hearing:
(gross) Right _____ Left _____
15 ft. Right _____ Left _____

IF REQUIRED:
Urinalysis: Sugar: _____ Albumin _____
Micro _____
Hgb or Hct (if indicated)_____

STS (may be required by some departments)
Date _____ Results _____
Recommendations _____

Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attached additional sheets if necessary)
Head, Ears, Nose, Throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Hernia			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			
Mammary			

A. Is there loss or seriously impaired function of any paired organs? Yes _____ No _____
Explain _____

B. Is student under treatment for any medical or emotional condition? Yes _____ No _____
Explain _____

C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited _____ Limited _____
Explain _____

D. Is student physically and emotionally healthy? Yes _____ No_____
Explain _____

Only for Students Admitted to a **HEALTH SCIENCES PROGRAM**

Based on my assessment of this student's physical and emotional health on _____(date), he/she appears able to participate in the activities of a health profession in a clinical setting. Yes _____ No_____
if no, please explain _____

_____ _____
Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

_____ _____
Print Name of Physician/Physician Assistant/Nurse Practitioner **Date**

Office Address **City** **State** **Zip Code**

*Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.