OHIO STATE UNIVERSITY ATHLETIC TRAINING DIVISION
ATHLETIC TRAINING STUDENT MEDICAL HISTORY

THE OHIO STATE UNIVERSITY

Student Instructions: Complete the first page (Medical History) and then have a physical examination where your provider (physician, PA-C or CNP) completes the second page (Physical Form). Once completed, send a copy of all pages to the OSU Wilce Student Health Center, ATTN: Preventative Medicine Nurse, 1875 Milikin Rd, Columbus, OH 43210-2200 AND uploaded copies into E*Value [https://www.e-value.net/login.cfm]. Copies must be received by JULY 15th. You will not be able to begin clinical rotations until this paperwork is on file.

Provider Instructions: This student must have a physical examination to determine whether he/she is cleared for full-participation in Athletic Training educational and patient care activities. Please review this history, perform a physical examination and determine whether they are cleared.

Full Name: _____ **OSU Student #** _____

Sex: ☐ **Male** ☐ **Female** **Date of Birth:** _____

MEDICATIONS (PRESCRIPTION and OVER THE COUNTER)

List any prescription medications you take or any over-the-counter medications or supplements you regularly use:

_____

_____

ALLERGIES

Are you allergic to/ or have you ever had an allergic reaction to any of the following (Check all that apply):

☐ Prescription or Over-the-Counter Medications: _____

☐ Seasonal Related Allergies ☐ Food and/or Drink products ☐ Bee Stings, Insect Bites, etc.

☐ Other: (please describe specific allergies): _____

Please describe allergy(ies) and reaction: _____

Have you ever been prescribed an Epi-Pen? ☐ Yes ☐ No

HEALTH HISTORY

Have you ever experienced any of the following during or after exercise / physical exertion? ☐ Yes ☐ No

- ☐ Chest Pain or Pressure
- ☐ Irregular Heart Beat (Palpitations), Heart Racing or Skipping
- ☐ Shortness of Breath
- ☐ Felt Dizzy or lightheaded
- ☐ Lost Consciousness or Passed Out
- ☐ Seizure

Please describe: _____

Have you ever been treated for or informed that you have (or have had) any of the following: ☐ Yes ☐ No

- ☐ Heart Condition, Disease or Infection
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Marfan's Syndrome
- ☐ Chronic Fatigue
- ☐ Tuberculosis
- ☐ Asthma or Exercise Induced Asthma
  - Do you use an inhaler? ☐ YES ☐ NO
- ☐ Sickle Cell Disease or Trait
- ☐ Clotting Disorders / Hemophilia
- ☐ Head Injury / Concussion
- ☐ Neurological Condition or Disease
- ☐ Seizure Disorder / Epilepsy
- ☐ Emotional / Psychological Condition
- ☐ Immune disorders or disease
- ☐ Chronic Infection / Hepatitis / HIV
- ☐ Diabetes or High Blood Sugar
- ☐ Hypoglycemia or Low Blood Sugar
- ☐ Abdominal or Stomach problems
- ☐ Hernia
- ☐ Back Pain, Injury or Condition
- ☐ Muscle, Joint, or Bone Injury or Condition
- ☐ Hearing problems
- ☐ Vision problems

If YES to any, please describe _____

_____

Have you ever been hospitalized or had surgery? ☐ Yes ☐ No

Please describe: _____

Have you even been medically disqualified from or not medically cleared for an activity? ☐ Yes ☐ No

Please describe: _____

Has anyone in your family died of heart problems or sudden death prior to age 50? ☐ Yes ☐ No

Please describe: _____

I affirm that all information contained in this medical history document is true and accurate to the best of my knowledge and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm from participating.

► **Student Signature:** _____ Date: _____

OHIO STATE UNIVERSITY ATHLETIC TRAINING DIVISION
ATHLETIC TRAINING STUDENT PHYSICAL EXAMINATION

THE OHIO STATE UNIVERSITY

Student Name: _____ **OSU Student #** _____

Date of Birth: _____ **Height:** _____ **Weight:** _____ **Pulse:** _____ **BP:** _____ / _____

SYSTEM	NORMAL	ABNORMAL FINDINGS
Head		
EENT		
Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Extremities		
Pulses		
Neurological		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back		
Hip		
Knee		
Ankle		
Foot		
Other:		

COMMENTS, RECOMMENDATIONS and PARTICIPATION STATUS

☐ **NOT Cleared** for Athletic Training Education and Patient Care Participation: _____

_____

_____

Examining Physician / PA-C / CNP Print Name: _____

Examining Physician / PA-C / CNP ▶ Signature: _____ Date: _____

☐ **CLEARED** for Athletic Training Education and Patient Care Participation:

☐ **CLEARED** with Recommendations: _____

_____

Examining Physician / PA-C / CNP Print Name: _____

Examining Physician / PA-C / CNP ▶ Signature: _____ Date: _____