

**HEALTH HISTORY**

**Family History.** Please circle the following if any of your blood relatives have had any of the diseases stated below:

- |                     |                     |
|---------------------|---------------------|
| Diabetes            | Cancer              |
| Heart Disease       | Eczema              |
| High Blood Pressure | Epilepsy            |
| Stroke              | Kidney Disease      |
| Arthritis           | Chemical Dependency |
| Asthma              | Mental Illness      |
| Stomach Ulcer       | Depression          |
| Tuberculosis        | Other _____         |

**Allergic Reaction To:** Please circle if you are allergic to any of the following:

- Penicillin \_\_\_\_\_  
 Sulfa \_\_\_\_\_  
 Erythromycin \_\_\_\_\_  
 Serum Food (Specify) \_\_\_\_\_  
 Other Drugs/Insects (Bees) \_\_\_\_\_

**Regular Medications (Birth Control, Supplements/Vitamins)**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

Do you have a health or medical problem requiring ongoing treatment: \_\_\_\_\_

Have you had any surgeries other than a tonsillectomy? \_\_\_\_\_

Have you ever been hospitalized? \_\_\_\_\_

Do you have any missing organs (eye, kidney, testicle)? \_\_\_\_\_

Have you ever had any concussions? \_\_\_\_\_

Have any of your family members (mom, dad, aunt, uncle, grandmother, grandfather) had a heart attack or stroke at less than 55 years of age? \_\_\_\_\_

Do you ever have racing of your heart or skipped heartbeats? \_\_\_\_\_

Do you wear glasses or contact lenses? \_\_\_\_\_

Do you have dental bridges, braces, or plates? \_\_\_\_\_

**Infectious Diseases.** Please circle any of the following you have had:

- |                        |                 |
|------------------------|-----------------|
| Measles                | Mumps           |
| German Measles         | Chicken Pox     |
| Recurrent Strep Throat | Infectious Mono |
| Pneumonia/Bronchitis   | Rheumatic Fever |
| Other: _____           |                 |

**Personal Health Problems/Diseases.** Please circle any of the following you have had:

- |                         |                             |
|-------------------------|-----------------------------|
| Acne/Eczema/Hives       | Recurrent Colds             |
| Ear Infections          | Eye Problems                |
| Chronic/Recurrent Cough | Chest Pain                  |
| Heart Disease/Murmurs   | Asthma/Hayfever             |
| High Blood Pressure     | Tuberculosis                |
| Jaundice                | Diarrhea/Constipation       |
| Urinary Infections      | Kidney Disease              |
| Joint Disease/Arthritis | Recurrent Headaches         |
| Seizures/Epilepsy       | Fainting spells             |
| Weakness/Paralysis      | Goiter/Thyroid Problem      |
| Tumors/Cysts/Cancer     | Diabetes                    |
| Eating Disorder         | Frequent Anxiety/Depression |
| Sleep Problems          | Other _____                 |

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

I hereby authorize the University of Minnesota Duluth to inspect or secure copies of medical case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A photocopy of this authorization shall be deemed as effective and valid as the original. I have read the letter regarding UMD's insurance policy and understand my responsibilities.

Parent's Signature: \_\_\_\_\_

Student's Signature: \_\_\_\_\_

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### PHYSICAL EXAMINATION

PATIENT'S NAME											
HEIGHT			WEIGHT			BLOOD PRESSURE			PULSE		

<b>VISION</b>	Without glasses	<b>NEAR</b>	<b>R</b>	<b>L</b>	<b>FAR</b>	<b>R</b>	<b>L</b>	<b>with glasses</b>	<b>NEAR</b>	<b>R</b>	<b>L</b>	<b>FAR</b>	<b>R</b>	<b>L</b>	<b>COLO</b>
															<b>R VISIO N</b>

AUDIOMETRY						
500	1000	2000	3000	4000	6000	8000

RT \_\_\_\_\_

LT \_\_\_\_\_

PHYSICAL	N	A	PHYSICAL	N	A	PHYSICAL	N	A
Skin			Thyroid			Abdomen		
Eyes			Lymph glands			Genitals		
Ears			Chest			Hernia		
Nose and sinuses			Breasts			Spine and back		
Throat			Lungs			Extremities/joints		
Teeth and gums			Heart			Neurological		

Comments regarding abnormal findings \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Lab, X-ray, Spirometry \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician's assessments, restrictions \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Suitable: \_\_\_\_\_ Not Suitable: \_\_\_\_\_

Date: \_\_\_\_\_ Examining Physician: \_\_\_\_\_

Signature \_\_\_\_\_

Name - printed \_\_\_\_\_