Wichita State University
Master of Science in Athletic Training
1845 Fairmount
Wichita, KS 67260-0016

REPORT OF MEDICAL HISTORY

Last Name: ____________________ First Name: ______________ MI: _________

SS#: ____________________ Gender (circle): F or M Date of Birth: _____________

WSU Address: ________________________ Zip: ________ Phone: _____________

Permanent Address: ______________________________________ Phone: _____________

City: __________________________ State: _____________ Zip: _______________

E-mail: ____________________________________ Cell Phone: ______________________

A) Family History:

Medical Condition:			**Family Member:**
Asthma	YES	NO	___________________
Allergies	YES	NO	___________________
Cancer	YES	NO	___________________
Diabetes	YES	NO	___________________
Headaches/Migraines	YES	NO	___________________
Heart Conditions	YES	NO	___________________
High Blood Pressure	YES	NO	___________________
High Cholesterol	YES	NO	___________________
Liver Disease	YES	NO	___________________
Seizures	YES	NO	___________________
Thyroid Problems	YES	NO	___________________
Ulcer Problems	YES	NO	___________________
Vision/Eye Problems	YES	NO	___________________
Other Conditions	YES	NO	___________________

If yes, please specify: ____

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B) Personal History:

Medical Condition:			**Date:**
Asthma	YES	NO	____________________
Allergies	YES	NO	____________________
Cancer	YES	NO	____________________
Depression	YES	NO	____________________
Diabetes	YES	NO	____________________
Headaches/Migraines	YES	NO	____________________
Heart Conditions	YES	NO	____________________
High Blood Pressure	YES	NO	____________________

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D) Communicable Disease Screening:

2. Are you taking any medications daily? YES NO

If yes, please specify: ____

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3. Have you ever been hospitalized for any surgeries or major illnesses? YES NO

If yes, please specify: ____

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I certify to the best of my knowledge that the information on this form is true and accurate.

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Signature of Student (Parent or legal guardian if less than 18 years of age) Date