Original Date:
Dates Revised:

Troy University

Athletic Training Student Health Participation Form

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
School Address	
School Phone	**Class (year in school)**
Previous or referring doctor:	**Date of last physical exam:**

Parent's name(s):

Parent or Permanent Address:

Parent Phone number(s): Father _____
Mother _____

In an EMERGENCY, if parents cannot be contacted, notify:

Name:

Address:

Phone Number:

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	○ Yes	○ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Alcohol	Do you drink alcohol?			○ Yes	○ No
	If yes, what kind?				
	How many drinks per week?				
	Have you ever experienced blackouts?			○ Yes	○ No
	Are you prone to "binge" drinking?			○ Yes	○ No
	Do you drive after drinking?			○ Yes	○ No
Tobacco	Do you use tobacco?			○ Yes	○ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			○ Yes	○ No
	Have you ever given yourself street drugs with a needle?			○ Yes	○ No

Review of Systems and Physical Exam

Vital Signs	*Ht*	*Wt*	*BP*	*Pulse*

To be completed by Health Care Provider

Review of Systems **Check each box for normal. For ABNORMAL write in the response.**	Notes:

☐ General	☐ Neurological	☐ Endocrine
☐ Skin	☐ Chest/Heart	Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Genitaila	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	☐ Psychiatric

To be completed by Health Care Provider

Physical Exam	**GENERAL MEDICAL** **check box for normal**	
☐	Head	
☐	Eyes	
☐	Ears	
☐	Nose	
☐	Neck	
☐	Thyroid	
☐	Nodes	
☐	Heart	
☐	Lungs	
☐	Breasts	
☐	Abdomen	
☐	Extremities	

I hereby certify that, _____, this Athletic Training student was
(Student's name)

examined by me on_____. At that time no physical or mental condition was detected
(Date)
which would reasonably be anticipated to render this Athletic Training student physically or mentally

unfit to engage in the requirements of an Athletic Training student.

_____ _____

Health Care Provider Signature **Date**

I, _____ have been informed by an Athletic Training Education
(Student's name)
Department representative, in the presence of a witness, and understand that Troy University is not liable

for any and all injuries that I may incur while participating as an Athletic Training student.

Student's Signature _____ Date _____

Representative _____ Date _____

Witness _____ Date _____

ATTENTION ALL ATHLETIC TRAINING STUDENTS
Troy University will not be responsible for any of your medical bills unless you have a current insurance questionnaire form on file at the Curriculum Director's Office.

PHYSICAL REQUIREMENTS FOR ALL ATHLETIC TRAINING STUDENTS
Everyone must be able to lift over fifty pounds.