BYU Student Health Center
PERSONAL MEDICAL HISTORY
-- PHYSICAL EXAMINATION

COMPLETE AND SIGN THIS PAGE

Name: _____ **Birthdate:** ___/___/___ *(MM/DD/YY)* **Today's Date:** ___/___/___ *(MM/DD/YY)*

Gender: M F (Circle one) **Marital Status: S M D W** (Circle one)

Reason for physical exam: ☐ Program Admission ☐ Athletic ☐ Other: _____

MEDICAL HISTORY (Please be specific)

- List Current Medications (including vitamins and supplements):
- History of adverse reaction to medication:
- List chronic medical conditions:
- List surgeries:
- Number of pregnancies: _____ Are you pregnant now? ☐ YES ☐ NO

FAMILY HISTORY (Parents and siblings, only. If YES, indicate relationship.)

	Relationship	YES	NO		*Relationship*	YES	NO
Cancer	_____	☐	☐	Blood Disorder	_____	☐	☐
High Blood Pressure	_____	☐	☐	Heart Disease	_____	☐	☐
Diabetes	_____	☐	☐	High Cholesterol	_____	☐	☐
Bowel disease	_____	☐	☐	Stroke	_____	☐	☐
Mental illness	_____	☐	☐	Arthritis	_____	☐	☐
Other: _____					_____	☐	

Explain: _____

REVIEW OF SYSTEMS (Check any symptoms you are experiencing.)

☐ Headaches	☐ Palpitations	☐ Frequent infections
☐ Dizziness	☐ Nausea/Vomiting	☐ Pelvic pain
☐ Fainting	☐ Diarrhea	☐ Vaginal discharge
☐ Seizures	☐ Constipation	☐ Joint swelling / pain / stiffness
☐ Sinus disease	☐ Abdominal pain	☐ Fatigue
☐ Cough	☐ Skin rashes / lesions	☐ Insomnia
☐ Chest Pain	☐ Mass (es) / lumps	☐ Anxiety / depression
☐ Shortness of breath	☐ Irregular menstrual periods	☐ Other

Explain: _____

_____

_____ _____/_____/_____

(Signature of Patient) **(Date)**

PHYSICAL EXAM

Height: _____ Weight: _____ Temperature: _____

Pulse: _____ BP: _____ Visual Acuity: R_____L_____OU_____

Corrected? ☐ *YES* ☐ *NO*

	Normal	Abnormal	Not Examined	Explain
• Skin	☐	☐	☐	_____
• Eyes	☐	☐	☐	_____
• Ears	☐	☐	☐	_____
• Nose	☐	☐	☐	_____
• Throat	☐	☐	☐	_____
• Neck	☐	☐	☐	_____
• Thyroid	☐	☐	☐	_____
• Lungs	☐	☐	☐	_____
• Heart	☐	☐	☐	_____
• Abdomen	☐	☐	☐	_____
• Back	☐	☐	☐	_____
• Musculoskeletal	☐	☐	☐	_____
• Neuro	☐	☐	☐	_____
• Genitalia	☐	☐	☐	_____
• Pelvic	☐	☐	☐	_____
• Breasts	☐	☐	☐	_____
• Psychological	☐	☐	☐	_____

LABS:

ASSESSMENT:

PLAN:

Examiner:
Brigham Young University
Student Health Center
PO Box 24800
1750 N Wymount Terrace Drive
Provo UT 84602
(801)422-2771 Fax: (801)422-0761

Name of Examiner: _____
(Please print)

Signature: _____ _____/_____/_____
(Date)

License No.:_____ **State:** _____

PREPARTICIPATION ATHLETIC PHYSICAL EVALUATION

NAME:	DATE OF EXAMINATION:

HISTORY (If the answer to any question is "yes," please describe in the space provided.)

1. Have you seen a doctor for an illness or injury since your last physical?	12. Do you have any current skin problems such as rash or fungus?
2. Have you ever been hospitalized overnight?	13. Have you ever been knocked out or lost your memory?
3. Are you currently taking any prescription or over-the-counter medications?	14. Have you ever had a seizure?
4. Have you ever taken any supplements to help you gain/lose weight or improve your performance?	15. Do you have frequent or severe headaches?
5. Have you had mono in the last two months?	16. Have you ever had a stinger, burner, or pinched nerve that stopped you from playing sports?
6. Have you ever passed out during or after exercise?	17. Do you cough, wheeze or have trouble breathing during or after activity?
7. Have you ever had chest pain during or after exercise?	18. Do you use any special protective or corrective equipment such as a knee brace?
8. Have you ever had racing of your heart or skipped heartbeats?	19. Have you ever had a sprain or swelling after injury that stopped you from playing sports?
9. Have you ever had high blood pressure?	20. Have you ever broken or fractured any bones?
10. Has any family member died of heart problems or of sudden death before age 50?	21. Have you ever dislocated any joints?
11. Has a physician ever denied or restricted your participation in sports for any medical problem?	22. Have you ever had any surgeries?