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:__**

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.

____

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