

**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	_____

High Cholesterol (ab) (h) (T2 Tct) Tj Tct 2 2 5 (-) -25 (-) -25 ) (.0 Tw (P) 2 (e) refEMC0 Tw (P) 2 (e) refEMC0 Tw (P)

***D) Communicable Disease Screening:***

2. Are you taking any medications daily? YES NO  
If yes, please specify: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Have you ever been hospitalized for any surgeries or major illnesses? YES NO  
If yes, please specify: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***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

