



thresh-ers



RECOMMENDED MEDICAL EXAMINATION FORM

When completed, this form should be returned to Bethel College.

STUDENT INSTRUCTIONS: EVERY STUDENT ATHLETE enrolling at **Bethel College** is required to present a report of his/her medical history and physical examination on this form. The student is to fill in all of the personal data and medical history below. Your physician can help you with the medical history.

This form must be mailed or presented in person to: _____ before enrollment.

TYPE or BLOCK PRINT the INFORMATION BELOW:

Name _____ Race _____ Male _____ Female _____
 Last First Middle

Age _____ Date of Birth _____ Marital Status: S _____ M _____ D _____ W _____

Enrolling as: Freshman _____ Sophomore _____ Junior _____ Senior _____ Graduate _____ Special _____

Home address _____
 Street City State (country) Zip

MEDICAL HISTORY (To be filled out by the student and checked with physician before examination)

FAMILY HISTORY:

| Relation | Age | State of Health | If Deceased, Cause of Death | Age at Death | Has <u>any</u> blood relation had: check each item | | |
|----------|-----|-----------------|-----------------------------|--------------|---|----|------------------------|
| | | | | | Yes | No | |
| Father | | | | | Yes | No | Asthma, Hay Fever |
| Mother | | | | | Yes | No | Allergy to Drugs |
| Brothers | | | | | Yes | No | Hypertension |
| | | | | | Yes | No | Diabetes |
| | | | | | Yes | No | Heart Trouble |
| Sisters | | | | | Yes | No | Kidney Trouble |
| | | | | | Yes | No | Rheumatism (Arthritis) |
| | | | | | Yes | No | Sickle Cell |

Have you ever had or have you now:

| | | | | | | | | |
|-----|----|------------------|-----|----|----------------------|-----|----|-------------------|
| Yes | No | Albumin in urine | Yes | No | Fainting Spells | Yes | No | Pleurisy |
| Yes | No | Arthritis | Yes | No | German Measles | Yes | No | Poliomyelitis |
| Yes | No | Anemia | Yes | No | Hay Fever | Yes | No | Rectal Trouble |
| Yes | No | Appendicitis | Yes | No | Frequent Headaches | Yes | No | Rheumatic Fever |
| Yes | No | Asthma | Yes | No | Heart Murmur | Yes | No | Scarlet Fever |
| Yes | No | Back Trouble | Yes | No | Heart Trouble | Yes | No | Sinusitis |
| Yes | No | Bloody Urine | Yes | No | High Blood Pressure | Yes | No | Skin Disorder |
| Yes | No | Chicken Pox | Yes | No | Histoplasmosis | Yes | No | Spitting Blood |
| Yes | No | Chronic Cough | Yes | No | Infectious Hepatitis | Yes | No | Tendency to Bleed |
| Yes | No | Convulsions | Yes | No | Inf. Mononucleosis | Yes | No | Thyroid Trouble |
| Yes | No | Deafness | Yes | No | Jaundice | Yes | No | Tonsillitis |
| Yes | No | Diabetes | Yes | No | Kidney Trouble | Yes | No | Tuberculosis |
| Yes | No | Duodenal Ulcer | Yes | No | Measles | Yes | No | Venereal Disease |
| Yes | No | Colitis | Yes | No | Meningitis | Yes | No | Whooping Cough |
| Yes | No | Earache | Yes | No | Migraine | Yes | No | Other Disorders |
| Yes | No | Encephalitis | Yes | No | Mumps | Yes | No | |

IMMUNIZATIONS (Please State the Year Received)

Tetanus _____ Polio _____ Influenza _____

Others (Please list) _____

Other illnesses or complaints (Please list) _____

Injuries (broken bones, head, neck, and joint injuries, etc.) _____

Allergies to drugs, foods, plants, others _____

Medications taken regularly _____

Absence of paired organ (kidney, eye, reproductive organs, etc) _____

FEMALES ONLY:

Do you menstruate regularly? _____

Any trouble with your periods? _____

