University of Maine, Athletic Training Education Program, Orono, ME 04469

Name: _____ SS#: _____ DOB: _____

Allergies to Meds: _____ Medications: _____

Date: _____ Time: _____ Citizenship: ❍ US ❍ Other ❍ Male ❍ Female

T: _____ **Visual Acuity:**

P: _____ Uncorrected Rt: _____ Lt: _____

B/P: _____ Corrected Rt: _____ Lt: _____

HT: _____

WT: _____ **Color Vision:** ❍ Normal ❍ Abnormal

PFT: _____ **Patient Wears:** ❍ Glasses ❍ Contacts ❍ No Correction

IMMUNIZATIONS

MMR _____

Td _____

Hep B Dose #1 _____ Dose #2 _____ Dose #3 _____

PPD Date Given: _____ Date Read: _____ Results: _____ (if ⊕ chest x-ray is required)

HEALTH HISTORY

	YES	NO	Comments		YES	NO	Comments
Asthma or Allergies				Jaundice			
Back Problems				Kidney Disease			
Blood Disorder				Migraine Headaches			
Chronic Lung Disease				Menstrual Problems			
Chronic Skin Disease				Mononucleosis			
Colitis				Mumps			
Concussion				Rheumatic Fever			
Diabetes				Scarlet Fever			
Epilepsy				Seizure Disorder			
Fractures				Surgery			
German Measles				Tuberculosis			
Hearing Loss				Ulcer			
Heart Disease				Vision Problems			
Hepatitis				Date of Last Physical Exam: _____			
Hernia				Date of Last Eye Exam: _____			
High Blood Pressure				Date of Last Dental Exam: _____			

Notes: _____

Family History: _____

Please mail completed form to:
Sherrie Weeks – Program Director
University of Maine
108 Lengyel Hall
Orono, ME 04469

PATIENT CONSENT FOR RELEASE OF INFORMATION

I authorize the release of the above information to the University of Maine College of Education and Human Development

Patient Signature:_____ Date:_____

Clinician Signature:_____ Date:_____

University of Maine, Athletic Training Education Program, Orono, ME 04469

Name: _____ SS#: _____ DOB: _____

Allergies to Meds: _____ Medications: _____

Date: _____ Time: _____ Citizenship: ❍ US ❍ Other ❍ Male ❍ Female

T: _____ ❍ **Health History Reviewed**

P: _____ **Notes:** _____

B/P: _____

HT: _____

WT: _____

PFT: _____

Normal	System	Abnormal	
	Head		
	Eyes		
	Ears		
	Nose		
	Sinus		
	Throat		
	Neck		
	Chest		
	CV		
	Abd.		
	Genital		
	Skin		
	Ext.		
	Neuro		
	Other		

Notes:

Assessment:

X-Rays:

Plan:

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Clinician Signature:_____ Date:_____