LANGSTON UNIVERSITY

**School of Physical Therapy**

*Review the medical information documents provided by Langston University BEFORE completing the medical history requirements. All new students must complete both pages of this form*

P.O. Box 1500
Langston, OK 73050
405.466.3335

*Please indicate the first semester you will attend:*

❑ Fall 20_____
❑ Spring 20_____
❑ Summer 20_____

# Medical History (Part 1)

Name: ❑ Male ❑ Female
*Last* *First* *Middle*

Social Security # or I.D.#: Date of Birth:

❑ Citizenship U.S. ❑ Other (Specify)

EMERGENCY CONTACT INFORMATION

*Name* *Relationship* *Phone (home)*

**MEDICAL HISTORY** – Have you ever had any of the following: (check if applicable)

❑ Alcohol Abuse
❑ Back Problems
❑ Convulsions/Seizures
❑ Drug Abuse
❑ Headache Chronic/Migraine
❑ High Blood Pressure
❑ Intestinal/Stomach Disorders
❑ Menstrual Problems/Pains
❑ Psychological Counseling
❑ Loss of Consciousness/Fainting
❑ Positive TB Skin Test
❑ Chronic Sinus Infections

❑ Anemia
❑ Chronic Cough
❑ Depression
❑ Eating Disorder
❑ Heart Disease
❑ High Cholesterol
❑ Malaria
❑ Orthopedic Problems
❑ Sickle Cell Disease
❑ Sleep Disorder
❑ Thyroid Disease
❑ Chicken Pox

❑ Arthritis
❑ Cancer
❑ Diabetes
❑ Chronic Hay fever
❑ Head Injury
❑ Heart Murmur
❑ Kidney Disease
❑ Pneumonia
❑ Rheumatic Fever
❑ Stroke
❑ Spleen Removed
❑ Chronic Bladder/Urinary Infections

❑ Asthma
❑ Colitis
❑ Disability
❑ Hepatitis
❑ Hernia
❑ Hemophilia
❑ Mono
❑ Polio
❑ Mumps
❑ TB
❑ Measles

Brief explanation of any POSITIVE responses:

History of Surgery: ❑ Yes ❑ No Ongoing Medical Problems: ❑ Yes ❑ No *(If yes, list below)*

Environmental Allergies:

Medication Allergies: ❑ Yes ❑ No *(List Medication/Reaction)*

List Current Medications:

Herbs:

Tobacco Use: ❑ Yes ❑ No Type: Frequency:

ALL INFORMATION PROVIDED IS CONFIDENTIAL

**To the physician:** Please read the Health History on the first page and comment on any condition which you consider significant. Immunization against tetanus and polio should be recent enough to be effective. All tests must be given and the results recorded.

# Physical Examination (Part 2)

(to be filled in by physician)

**Name**_____ **Date**_____

*Last* *First* *Middle*

## Measurements and Other Findings

| Height | Weight | Color/Hair | Color/Eyes | Build<br>Slender____ Medium____ Heavy____ Obese____ |
|---|---|---|---|---|

| Blood Pressure: | Pulse : | Vision: | Hearing: |
|---|---|---|---|

| Normal | Abnormal | Clinical Evaluation (Check each item for appropriate column: N.E. if not evaluated) | Notes - Describe every abnormality in detail. (Enter pertinent number before each comment; continue and use additional sheets if necessary). |
|---|---|---|---|
| | | **Head** | |
| | | **Ears (general)** | |
| | | **Eye (general)** | |
| | | **Nose** | |
| | | **Oropharynx** | |
| | | **Neck** | |
| | | **Lungs** | |
| | | **Heart** | |
| | | **Breast** | |
| | | **Abdomen** | |
| | | **Genitalia** | |
| | | **Musculoskeletal** | |
| | | **Neurological** | |
| | | **Psychiatric** | |

### Laboratory Findings

| Urinalysis: (required) | Albumin | Sugar | Microscopic | Hematocrit<br>Hemoglobin (women) |
|---|---|---|---|---|

| TB Skin Test (Tine or PPD) | Results of other pertinent laboratory tests & X-rays |
|---|---|

### Immunization History

| | Initial Series | Most Recent Booster | Other Immunizations-Date |
|---|---|---|---|
| **Polio** | | | |
| **Tetanus** | | | |

**Other Information or Comments**

| | | |
|---|---|---|
| **Do you consider this person in satisfactory health to pursue his or her studies?** | ❑ **Yes** | ❑ **No** |
| **Four hours of physical education are required for graduation.** | | |
| **Do you consider the applicant physically fit for physical exercise?** | ❑ **Yes** | ❑ **No** |
| **Limited exercise?** | ❑ **Yes** | ❑ **No** |

**Signed:**

*Signature of licensed physician* *Date*

**Name typed or printed:**