## WHEATON COLLEGE STUDENT HEALTH SERVICES MEDICAL HISTORY REPORT

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Father									Autoimmune disea	se						
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0.11.									Diabetes							
Siblings									Heart Disease							
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ERSONAL										se unki	nown)					
Have You	Had?		Y N			Y	N		before age 50 (cau		nown)	)			Y	
	Had?		Y N	Depressio	n/Anxiety	Y	N	Malaria	before age 50 (cau	se unki	nown)	) Sinus co			Y	
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Student's Signature (Required)\_\_\_\_\_\_

PARENTAL CONSENT: If your student is <18 years of age, please complete the Consent for Minors, found on the SHS website

Date

#### Wheaton College Complete Only If New Intercollegiate Athlete **Athletics Medical History**



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DOB:		1	Name:				Sport(s):			ID#:
in sports for any research         in sports for any research <td< td=""><td></td><td></td><td></td><td></td><td></td><td>DOB:</td><td></td><td>Sex:</td><td></td><td></td></td<>						DOB:		Sex:		
Yes? please crice.         22. Here you had a box or point hury that required x-rays.         Yes/No           Image: A strime         Chicken Pox         Makes         Heat liness.           Image: A strime         Chicken Pox         Makes         Heat liness.           Image: A strime         Chicken Pox         Mark CT, surgery, injections, nethalitation, physical therapy, a trace, act, or crickhes?           3. A ray ou criently taking any prescription (over-the-courter) medications?         Yes/No           4. Do you congr. Wheeza, or have difficulty breathing during Yes/No         Yes/No           6. Are you coulds, wheeza, or have difficulty breathing during Yes/No         Yes/No           6. Are you coulds, wheeza, or have difficulty breathing during Yes/No         Yes/No           6. Are you warding supplements?         Yes/No           7. Do you or a family member have an fistion of asthma or yes/No         Yes/No           7. Do you or a family member have an fistion or dist function of Yes/No         Yes/No           7. Do you are any swith addies photeles, cit/s         Yes/No           7. How you had any chronic medical problems (chronic         Yes/No           7. How you were failed or you werefailed or you were failed or you werefailed or you were			in sports for	any reaso	on?					sprain, strain, tendonitis, fracture, stress fracture, dislocation,
Earner         Cancer         Astma         Chicken Pox         Diabetes         Hearitis           Hepatitis         Hemina         Pneumonia         Ulcara         Measlas         brace, a cast. or crutches?           Nono         HighLow Biod Sugar         Birth Deformities         Thithes         The you under ny fractures or stress fractures in the past Yes/No prescription (over-the-councily medications?           A fer you currently taking any prescription or non- prescription (over-the-councily medications?         Yes/No           5. Are you taking supplements?         Yes/No           6. Are you baing member have a history of astma or Yes/No or alter exercise?         Yes/No           7. Bo you or a family member have a history of astma or Yes/No or alter exercise?         Yes/No           8. Were you bern without, missing, or have lost function of Yes/No an organ character stress, past, muthout guards, yes, testice, etc.?         Yes/No           10. Have you had any chronic medical problems (chronic Yes/No rately you had any chronic medical problems (chronic Yes/No rately you ever raped/encad any of the lollowing?         Yes/No           11. Da you were rgisses or contrasts for athelies?         Yes/No           12. Have you were raped/encad any of the lollowing?         Yes/No           13. Da you regularly use braces, past, muth guards, Yes/No         Setures f. Diplepsy         Yes/No           14. Have you weer raped/encad any of home deficion praset out		2.	Do you have							etc.) that caused you to miss a practice or game?
Heading         Prescription			"Yes" please circle.			-		-	22. Have you had a bone or joint injury that required x-rays, Yes/N	
3. Are you currently taking any prescription or non- prescription (vor+r, there counter) medications?       Yes/No         3. Are you currently taking any prescription or non- stringing inserts?       Yes/No         6. Do you have allergies to medicines, pollens, foods, or stringing inserts?       Yes/No         7. Are you bays upterents?       Yes/No         8. Are you care finally member have a history of asthma or or after exercise?       Yes/No         9. Do you or a family member have a history of asthma or exercise-induced bronchespasms?       Yes/No         9. Do you are a family member have a history of asthma or exercise-induced bronchespasms?       Yes/No         9. Do you are a family member have a history of asthma or exercise-induced bronchespasms?       Yes/No         10. Bo you are a family member have a history of asthma or exercise-induced bronchespasms?       Yes/No         10. Do you nave any skin disorders (herpes, cold sores, rashes, acne, eczma)?       Yes/No         11. Do you wear glasses co contracts for affective file/s?       Yes/No         12. Have you ever releaved diming exercise?       Yes/No         13. Do you ever releaved diming exercise?       Yes/No         14. Have you ever releaved diming exercise?       Yes/No         15. Have you ever releaved diming exercise?       Yes/No         16. Does you relatificus or papead out during or pressure in your chest during exercise?       Yes/No         17.			Cancer	Asthma	Chicken Pox	Diabetes	Heat Illnes		MRI, CT, surgery, injections, rehabilitation, physical therapy,	
3. Are you currently taking any prescription or non- prescription (vor+r, there counter) medications?       Yes/No         3. Are you currently taking any prescription or non- stringing inserts?       Yes/No         6. Do you have allergies to medicines, pollens, foods, or stringing inserts?       Yes/No         7. Are you bays upterents?       Yes/No         8. Are you care finally member have a history of asthma or or after exercise?       Yes/No         9. Do you or a family member have a history of asthma or exercise-induced bronchespasms?       Yes/No         9. Do you are a family member have a history of asthma or exercise-induced bronchespasms?       Yes/No         9. Do you are a family member have a history of asthma or exercise-induced bronchespasms?       Yes/No         10. Bo you are a family member have a history of asthma or exercise-induced bronchespasms?       Yes/No         10. Do you nave any skin disorders (herpes, cold sores, rashes, acne, eczma)?       Yes/No         11. Do you wear glasses co contracts for affective file/s?       Yes/No         12. Have you ever releaved diming exercise?       Yes/No         13. Do you ever releaved diming exercise?       Yes/No         14. Have you ever releaved diming exercise?       Yes/No         15. Have you ever releaved diming exercise?       Yes/No         16. Does you relatificus or papead out during or pressure in your chest during exercise?       Yes/No         17.			Hepatitis	Hemia	Pneumonia	Ulcers	Measles		DIC	a brace, a cast, or crutches?
3. Are you currently taking any prescription or non- prescription (vor+r, there counter) medications?       Yes/No         3. Are you currently taking any prescription (vor+r, there counter) medications?       Head       Hand       Wrist       Neck       Chest         4. Do you have allergies to medicines, pollens, foods, or stringing inserts?       Yes/No       Yes/No       Ankle       Shoulder         6. Do you cough, wheeze, or have difficulty breathing during Yes/No or after exercise?       Yes/No       Yes/No       Yes/No         70       Do you or a family member have a history of asthma or exercise-induced bronchespasms?       Yes/No       Yes/No         9. Do you are affamily member have a history of asthma or exercise-induced bronchespasms?       Yes/No       Yes/No         10. Have you have any skin disorders (herpes, cold sores, rashes, acne, ezema)?       Yes/No       Yes/No         11. Do you wear glasses cor contracts for affective file/s?       Yes/No         12. Have you ever failed any problems with your vision?       Yes/No         13. Do you ever rescues in your chest during exercise?       Yes/No         14. Have you ever related or passed out during or Yes/No       Yes/No         15. Have you ever related or passed out during or Yes/No       Yes/No         16. Does you relatify use failed?       Yes/No         17. Have you ever related for you rescription       Yes/No <tr< td=""><td></td><td></td><td>Mono</td><td>High/Low</td><td>/ Blood Sugar</td><td>Birth Defo</td><td>ormities</td><td></td><td>- EE</td><td></td></tr<>			Mono	High/Low	/ Blood Sugar	Birth Defo	ormities		- EE	
3. Are you currently taking any prescription or non- prescription (vor+r, there counter) medications?       Yes/No         3. Are you currently taking any prescription or non- stringing inserts?       Yes/No         6. Do you have allergies to medicines, pollens, foods, or stringing inserts?       Yes/No         7. Are you bays upterents?       Yes/No         8. Are you care finally member have a history of asthma or or after exercise?       Yes/No         9. Do you or a family member have a history of asthma or exercise-induced bronchespasms?       Yes/No         9. Do you are a family member have a history of asthma or exercise-induced bronchespasms?       Yes/No         9. Do you are a family member have a history of asthma or exercise-induced bronchespasms?       Yes/No         10. Bo you are a family member have a history of asthma or exercise-induced bronchespasms?       Yes/No         10. Do you nave any skin disorders (herpes, cold sores, rashes, acne, eczma)?       Yes/No         11. Do you wear glasses co contracts for affective file/s?       Yes/No         12. Have you ever releaved diming exercise?       Yes/No         13. Do you ever releaved diming exercise?       Yes/No         14. Have you ever releaved diming exercise?       Yes/No         15. Have you ever releaved diming exercise?       Yes/No         16. Does you relatificus or papead out during or pressure in your chest during exercise?       Yes/No         17.				-		e	Tuberculosi	s	θH	
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The second sec		3.						No	0	
Top         Thick by purposed         Top you have allergies to medicines, pollens, foods, or Yes/No           stinging insacts?         Arm by purposed         Thick by purpos			-	-						
B. Were you born without, missing, or have lost function of Yes/No an organ (ovary, kidney, eye, testicle, etc.)?         Head injury or concussion / How Many?         Yes/No           9. Do you have any skin disorders (herpes, cold sores, rashes, acne, eczema)?         Yes/No         Seizures / Epilepsy         Yes/No           10. Have you have any skin disorders (herpes, cold sores, rashes, acne, eczema)?         Yes/No         Seizures / Epilepsy         Yes/No           11. Do you wear glasses or contacts for athietics?         Yes/No         Seizures / Epilepsy         Yes/No           12. Have you regularly use braces, pad, mouth guards, assistive devices, neck rolls, goggles, etc. ?         Head aches with exercise         Yes/No           14. Have you ever received chiropractic care?         Yes/No         Head aches with exercise         Yes/No           15. Have you ever rata discornfort, pain, or pressure in your chest during exercise?         Yes/No         Ze         Have you ever had a period? Yes/ No Age of Onset?           16. Does your heat race or skip beats during exercise?         Yes/No         Ze         Have you gained or lost more than 10 lbs. in the past year?         Ze           19. Hast a doctor ever ordered a test for your heart fuel; Cholesterol         Yes/No         Yes/No         Yes/No           19. Hast a doctor ever ordered a test for your heart fuel; Cholesterol         Yes/No         Yes/No         Ze         Heave you gained or lost more than 10 lbs. in t	<b>IAI</b>	4.			/		, or Yes/	No		
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B. Were you born without, missing, or have lost function of Yes/No an organ (ovary, kidney, eye, testicle, etc.)?         Head injury or concussion / How Many?         Yes/No           9. Do you have any skin disorders (herpes, cold sores, rashes, acne, eczema)?         Yes/No         Seizures / Epilepsy         Yes/No           10. Have you have any skin disorders (herpes, cold sores, rashes, acne, eczema)?         Yes/No         Seizures / Epilepsy         Yes/No           11. Do you wear glasses or contacts for athietics?         Yes/No         Seizures / Epilepsy         Yes/No           12. Have you regularly use braces, pad, mouth guards, assistive devices, neck rolls, goggles, etc. ?         Head aches with exercise         Yes/No           14. Have you ever received chiropractic care?         Yes/No         Head aches with exercise         Yes/No           15. Have you ever rata discornfort, pain, or pressure in your chest during exercise?         Yes/No         Ze         Have you ever had a period? Yes/ No Age of Onset?           16. Does your heat race or skip beats during exercise?         Yes/No         Ze         Have you gained or lost more than 10 lbs. in the past year?         Ze           19. Hast a doctor ever ordered a test for your heart fuel; Cholesterol         Yes/No         Yes/No         Yes/No           19. Hast a doctor ever ordered a test for your heart fuel; Cholesterol         Yes/No         Yes/No         Ze         Heave you gained or lost more than 10 lbs. in t	<b>ERA</b>		or after exer	cise?						
B. Were you born without, missing, or have lost function of Yes/No an organ (ovary, kidney, eye, testicle, etc.)?         Head injury or concussion / How Many?         Yes/No           9. Do you have any skin disorders (herpes, cold sores, rashes, acne, eczema)?         Yes/No         Seizures / Epilepsy         Yes/No           10. Have you have any skin disorders (herpes, cold sores, rashes, acne, eczema)?         Yes/No         Seizures / Epilepsy         Yes/No           11. Do you wear glasses or contacts for athietics?         Yes/No         Seizures / Epilepsy         Yes/No           12. Have you regularly use braces, pad, mouth guards, assistive devices, neck rolls, goggles, etc. ?         Head aches with exercise         Yes/No           14. Have you ever received chiropractic care?         Yes/No         Head aches with exercise         Yes/No           15. Have you ever rata discornfort, pain, or pressure in your chest during exercise?         Yes/No         Ze         Have you ever had a period? Yes/ No Age of Onset?           16. Does your heat race or skip beats during exercise?         Yes/No         Ze         Have you gained or lost more than 10 lbs. in the past year?         Ze           19. Hast a doctor ever ordered a test for your heart fuel; Cholesterol         Yes/No         Yes/No         Yes/No           19. Hast a doctor ever ordered a test for your heart fuel; Cholesterol         Yes/No         Yes/No         Ze         Heave you gained or lost more than 10 lbs. in t	N.	7.	Do you or a	family me	ember have a his	tory of asthm	na or Yes/I	No	_	
0.       Weller you handling, kidney, eye, testicle, etc.)?       "Blacked out" / "Knocked out" / "Knocked out" / Yes/No         9.       Do you have any skin disorders (herpes, cold sores, Yes/No       Yes/No         10.       Have you had any chronic medical problems (chronic Yes/No       Yes/No         11.       Do you wear glasses or contacts for athletics?       Yes/No         12.       Have you had any problems with your vision?       Yes/No         13.       Do you regularly use braces, pads, mouth guards, assistive devices, neck rolls, goggles, etc.?       Yes/No         14.       Have you ever had disconfort, pain, or Yes/No       Yes/No         15.       Have you ever had disconfort, pain, or Yes/No       Yes/No         16.       Does your heart race or skip beats during exercise?       Yes/No         19.       Has a doctor ever ordered a test for your Yes/No       Yes/No         19.       Has a doctor ever ordered a test for your Yes/No       High Blood Pressure       Yes/No         19.       Has a doctor ever ordered a test for your Yes/No       Yes/No       26.       Have you ever had a period? Yes/No Age of Onset?       29.         19.       Has a doctor ever ordered a test for your       Yes/No       Yes/No       20.       Yes/No         19.       Has a doctor ever ordered a test for your       Yes/No       Yes/No <td>6</td> <td></td> <td>exercise-ind</td> <td>uced bror</td> <td>nchospasms?</td> <td></td> <td></td> <td></td> <td>-</td> <td></td>	6		exercise-ind	uced bror	nchospasms?				-	
air Organ (Way), Kulley, ey, tescille, Pitc.//?         9. Do you have any skin disorders (herpes, cold sores, Yes/No         10. Have you have any skin disorders (herpes, cold sores, Yes/No         10. Have you have any skin disorders (herpes, cold sores, Yes/No         11. Do you wear glasses or contacts for athletics?         12. Have you have any skin disorders (horpes, cold sores, Yes/No         13. Do you regularly use braces, pads, mouth guards, sistive devices, neck rolls, goggles, etc.?         14. Have you ever fainted or passed out during exercise?         15. Have you ever had discomfort, pain, or pressure in your chest during exercise?         16. Does your heart care or skip beast during exercise?         18. Has a doctor ever rold you that you have:         19. Haart Nickley (High Blood Pressure         19. Haart Murrur         19. Haart March         10. Have you aver fainted or passed out during or Yes/No         19. Haart Infection         19. Haart March         10. Heart Infection       Yes/No         10. Do you have ang assing out / Syncope         20. Do you have ang assing out / Syncope         20. Do you have a family history of the following:         20. Do you have a family history of the following:         21. Have you ever fained mark         22. Do you have a family history of the following:         23. Are you trying to gain or lo		8.	Were you bo	orn withou	it, missing, or hav	ve lost functi	ion of Yes/N	10	_	
12. Have you had any problems with your vision?       Yes/No         13. Do you regularly use braces, pads, mouth guards, Yes/No       Numbness, tingling, or weakness in your arms or legs       Yes/No         14. Have you ever neceived chiropractic care?       Yes/No         15. Have you ever had discomfort, pain, or       Yes/No         16. Does your heart race or skip beats during exercise?       Yes/No         17. Have you ever fainted or passed out during or       Yes/No         18. Has a doctor ever ordered a test for your       Yes/No         19. Has a doctor ever ordered a test for your       Yes/No         19. Has a doctor ever told you that you have:       Yes/No         19. Has a doctor ever told point frection       Yes/No         High Blood Pressure       Yes/No         Heart Infection       Yes/No         Abnormal Heart Beat       Yes/No         Stickle Cell Disease       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Ye			an organ (ov	vary, kidne	ey, eye, testicle,	etc.)?			н.	
12. Have you had any problems with your vision?       Yes/No         13. Do you regularly use braces, pads, mouth guards, Yes/No       Asistive devices, neck rolls, gogles, etc.?         14. Have you ever received chiropractic care?       Yes/No         15. Have you ever had discomfort, pain, or       Yes/No         16. Does your heart race or skip beats during exercise?       Yes/No         17. Have you ever fainted or passed out during or       Yes/No         18. Has a doctor ever ordered a test for your       Yes/No         19. Has a doctor ever ordered a test for your       Yes/No         19. Has a doctor ever told you that you have:       May you gained or lost more than 10 lbs. in the past yes/No         19. Has a doctor ever told pour have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No		9.	Do you have	any skin	disorders (herpe	s, cold sore	s, Yes/I	No	_ CA	Confusion or memory loss due to hit to head Yes/N
12. Have you had any problems with your vision?       Yes/No         13. Do you regularly use braces, pads, mouth guards, Yes/No       Asistive devices, neck rolls, gogles, etc.?         14. Have you ever received chiropractic care?       Yes/No         15. Have you ever had discomfort, pain, or       Yes/No         16. Does your heart race or skip beats during exercise?       Yes/No         17. Have you ever fainted or passed out during or       Yes/No         18. Has a doctor ever ordered a test for your       Yes/No         19. Has a doctor ever ordered a test for your       Yes/No         19. Has a doctor ever told you that you have:       May you gained or lost more than 10 lbs. in the past yes/No         19. Has a doctor ever told pour have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No			rashes, acne	e, eczema	a)?				B D	Seizures / Epilepsy Yes/N
12. Have you had any problems with your vision?       Yes/No         13. Do you regularly use braces, pads, mouth guards, Yes/No       Asistive devices, neck rolls, gogles, etc.?         14. Have you ever received chiropractic care?       Yes/No         15. Have you ever had discomfort, pain, or       Yes/No         16. Does your heart race or skip beats during exercise?       Yes/No         17. Have you ever fainted or passed out during or       Yes/No         18. Has a doctor ever ordered a test for your       Yes/No         19. Has a doctor ever ordered a test for your       Yes/No         19. Has a doctor ever told you that you have:       May you gained or lost more than 10 lbs. in the past yes/No         19. Has a doctor ever told pour have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No		10.	Have you ha	ad any chi	ronic medical pro	blems (chro	nic Yes/I	۱o	)Ľ	Hospitalization due to a concussion or mild traumatic Yes/N
12. Have you had any problems with your vision?       Yes/No         13. Do you regularly use braces, pads, mouth guards, Yes/No       Numbness, tingling, or weakness in your arms or legs       Yes/No         14. Have you ever neceived chiropractic care?       Yes/No         15. Have you ever had discomfort, pain, or       Yes/No         16. Does your heart race or skip beats during exercise?       Yes/No         17. Have you ever fainted or passed out during or       Yes/No         18. Has a doctor ever ordered a test for your       Yes/No         19. Has a doctor ever ordered a test for your       Yes/No         19. Has a doctor ever told you that you have:       Yes/No         19. Has a doctor ever told point frection       Yes/No         High Blood Pressure       Yes/No         Heart Infection       Yes/No         Abnormal Heart Beat       Yes/No         Stickle Cell Disease       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Ye			fatigue, thyro	oid condit	ion, diabetes, etc	:.)?			ğ	brain injury
12. Have you had any problems with your vision?       Yes/No         13. Do you regularly use braces, pads, mouth guards, Yes/No       Numbness, tingling, or weakness in your arms or legs       Yes/No         14. Have you ever neceived chiropractic care?       Yes/No         15. Have you ever had discomfort, pain, or       Yes/No         16. Does your heart race or skip beats during exercise?       Yes/No         17. Have you ever fainted or passed out during or       Yes/No         18. Has a doctor ever ordered a test for your       Yes/No         19. Has a doctor ever ordered a test for your       Yes/No         19. Has a doctor ever told you that you have:       Yes/No         19. Has a doctor ever told point frection       Yes/No         High Blood Pressure       Yes/No         Heart Infection       Yes/No         Abnormal Heart Beat       Yes/No         Stickle Cell Disease       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Ye			· ·				Yes/	No	Ē.	Headaches with exercise Yes/N
13. Do you regularly use braces, pads, mouth guards, assistive devices, neck rolls, goggles, etc.?       Yes/No         14. Have you ever received chiropractic care?       Yes/No         15. Have you ever had discomfort, pain, or pressure in your chest during exercise?       Yes/No         16. Does your heart race or skip beats during exercise?       Yes/No         17. Have you ever fainted or passed out during or after exercise?       Yes/No         18. Has a doctor ever ordered a test for your       Yes/No         19. Has a doctor ever ordered a test for your       Yes/No         High Blood Pressure       Yes/No         High Cholesterol       Yes/No         Heart Infection       Yes/No         Heart Infection       Yes/No         Sickle Cell Disease       Yes/No         Sickle Cell Disease       Yes/No         Meart Attack       Yes/No         20. Do you have a family history of the following:       Yes/No         21. Do you lawe a family history of the following:       34. Do you limit or carefully control what you eat?       Yes/No         22. Do you have a family history of the following:       Yes/No       Yes/No       34. Do you limit or carefully control what you eat?       Yes/No         20. Do you have a family history of the following:       Yes/No       Yes/No       Yes/No         20. Do you have a		12. Have you had any problems with your vision?						Numbness, tingling, or weakness in your arms or legs Yes/N		
assistive devices, neck rolls, goggles, etc.?       Inability to move a limb due to a hit or a fall       Yes/No         14. Have you ever had discomfort, pain, or       Yes/No         15. Have you ever had discomfort, pain, or       Yes/No         16. Does your heart race or skip beats during exercise?       26. Have you ever had a period? Yes/ No Age of Onset?         17. Have you ever fainted or passed out during or       Yes/No         after exercise?       27. How many periods have you had in the past year?         18. Has a doctor ever ordered a test for your       Yes/No         19. Has a doctor ever ordered a test for your       Yes/No         High Blood Pressure       Yes/No         High Cholesterol       Yes/No         Heart Infection       Yes/No         Abnormal Heart Beat       Yes/No         Sickle Cell Disease       Yes/No         Queden Death       Yes/No         10. Do you have a family history of the following:       34. Do you limit or carefully control what you eat?       Yes/No         20. Do you have a family history of Yes/No       Yes/No       Yes/No       Yes/No         20. Do you have a family history of the following:       Yes/No       34. Do you limit or carefully control what you eat?       Yes/No         20. Do you have a family history of the following:       Yes/No       Yes/No       Y		13.					Yes/	No		
11. Have you ever head discomfort, pain, or pressure in your chest during exercise?       Yes/No         15. Have you ever had discomfort, pain, or pressure in your chest during exercise?       Yes/No         16. Does your heart race or skip beats during or after exercise?       Yes/No         17. Have you ever fainted or passed out during or after exercise?       Yes/No         18. Has a doctor ever ordered a test for your       Yes/No         heart (i.e. EKG, echocardiogram)?       19. Has a doctor ever told you that you have:         19. Has a doctor ever told you that you have:       30. Have you gained or lost more than 10 lbs. in the past Yes/No         High Blood Pressure       Yes/No         Heart Infection       Yes/No         Heart Infection       Yes/No         Ahormal Heart Beat       Yes/No         20. Do you have a family history of the following:       Yes/No         20. Do you have a family history of the following:       Yes/No         20. De you have a family history of the following:       Yes/No         Stickle Cell Disease       Yes/No         Heart Attack       Yes/No         Heart Attack       Yes/No         Passing out / Syncope       Yes/No         Heart Attack       Yes/No         Passing out / Syncope       Yes/No         Heart Attack       Yes/No </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>									-	
pressure in your chest during exercise?       Yes/No         16. Does your heart race or skip beats during exercise?       Yes/No         17. Have you ever fainted or passed out during or       Yes/No         after exercise?       Duration of periods?         18. Has a doctor ever ordered a test for your       Yes/No         heart (i.e. EKG, echocardiogram)?       High Blood Pressure         19. Has a doctor ever told you that you have:       Yes/No         Heart Infection       Yes/No         Heart Infection       Yes/No         Abnormal Heart Beat       Yes/No         Sickle Cell Disease       Yes/No         Beath under Age 50       Yes/No         Heart Attack       Yes/No         Bessing out / Syncope       Yes/No         Sickle Cell Disease       Yes/No         Heart Attack       Yes/No         Heart Attack       Yes/No         Heart Disease       Yes/No         Heart Disease       Yes/No         Sickle Cell Disease <td></td>										
16. Does your heart race or skip beats during exercise?       Yes/No         17. Have you ever fainted or passed out during or gatter exercise?       Yes/No         18. Has a doctor ever ordered a test for your heart (i.e. EKG, echocardiogram)?       Duration of periods?         19. Has a doctor ever told you that you have:       Yes/No         High Blood Pressure       Yes/No         Heart Murmur       Yes/No         Heart Murmur       Yes/No         Heart Infection       Yes/No         Abnormal Heart Beat       Yes/No         Sickle Cell Disease       Yes/No         Death under Age 50       Yes/No         Heart Disease       Yes/No         Heart Attack       Yes/No         Heart Disease       Yes/No         Sickle Cell Disease       Yes/No         Heart Disease       Yes/No         Sickle Cell Disease		15.	-				res/i	NO		
17. Have you ever fainted or passed out during or safer exercise?       Yes/No         18. Has a doctor ever ordered a test for your heart (i.e. EKG, echocardiogram)?       Yes/No         19. Has a doctor ever told you that you have:       Yes/No         High Blood Pressure       Yes/No         Heart Murmur       Yes/No         Heart Infection       Yes/No         Heart Infection       Yes/No         Abnormal Heart Beat       Yes/No         Sickle Cell Disease       Yes/No         Death under Age 50       Yes/No         Heart Attack       Yes/No<		16	, ,		U		arcise? Ves/N			26. Have you ever had a period? Yes/ No Age of Onset?
after exercise?       28. Interval between periods? Duration of periods?         18. Has a doctor ever ordered a test for your heart (i.e. EKG, echocardiogram)?       29. Are you on medication for your periods? Yes/No         19. Has a doctor ever told you that you have:										<ol><li>How many periods have you had in the past year?</li></ol>
18. Has a doctor ever ordered a test for your       Yes/No         heart (i.e. EKG, echocardiogram)?       19. Has a doctor ever told you that you have:       29. Are you on medication for your periods?       Yes/No         19. Has a doctor ever told you that you have:       High Blood Pressure       Yes/No         High Cholesterol       Yes/No         Heart Infection       Yes/No         Abnormal Heart Beat       Yes/No         Sickle Cell Disease       Yes/No         Sudden Death       Yes/No         Heart Disease       Yes/No         Heart Attack       Yes/No         Heart Attack       Yes/No         Heart Attack       Yes/No         Beath ander Age 50       Yes/No         Heart Disease       Yes/No         Heart Attack       Yes/No         Heart Attack       Yes/No         Heart Disease       Yes/No         Heart Attack       Yes/No         Heart Disease       Yes/No         Heart Disease       Yes/No         Heart Attack       Yes/No         Heart Attack			-			aning of	103/1			28. Interval between periods? Duration of periods?
heart (i.e. EKG, echocardiogram)?       If "Yes", name of medication		18.			lered a test for vo	our	Yes/No			29. Are you on medication for your periods? Yes/No
19. Has a doctor ever told you that you have:       30. Have you gained or lost more than 10 lbs. in the past yes/No       Yes/No         High Blood Pressure       Yes/No       31. Are you happy with your weight?       Yes/No         Heart Murmur       Yes/No       32. Are you trying to gain or lose weight?       Yes/No         Abnormal Heart Beat       Yes/No       32. Are you trying to gain or lose weight?       Yes/No         20. Do you have a family history of the following:       Sudden Death       Yes/No       33. Has anyone recommended you change your weight yes/No       Yes/No         Beart Disease       Yes/No       Yes/No       34. Do you limit or carefully control what you eat?       Yes/No         Heart Attack       Yes/No       Yes/No       Yes/No       Yes/No       Yes/No         Heart Attack       Yes/No       Yes/No       Yes/No       Yes/No       Yes/No         Heart Disease       Yes/No       Yes/No       Yes/No       Yes/No       Yes/No       Yes/No         H	GΥ				-				ES	
High Cholesterol       Yes/No         Heart Murmur       Yes/No         Heart Infection       Yes/No         Abnormal Heart Beat       Yes/No         Sickle Cell Disease       Yes/No         20. Do you have a family history of the following:       31. Are you happy with your weight?       Yes/No         Sudden Death       Yes/No         Death under Age 50       Yes/No         Heart Attack       Yes/No         Heart Attack       Yes/No         Passing out / Syncope       Yes/No         Sickle Cell Disease       Yes/No         Heart Attack       Yes/No         Heart Migh Blood Pressure       Yes/No		19.				ve:			AL	30. Have you gained or lost more than 10 lbs. in the past Yes/No
High Cholesterol       Yes/No         Heart Murmur       Yes/No         Heart Infection       Yes/No         Abnormal Heart Beat       Yes/No         Sickle Cell Disease       Yes/No         20. Do you have a family history of the following:       31. Are you happy with your weight?       Yes/No         Sudden Death       Yes/No         Death under Age 50       Yes/No         Heart Attack       Yes/No         Heart Attack       Yes/No         Passing out / Syncope       Yes/No         Sickle Cell Disease       Yes/No         Heart Attack       Yes/No         Fear Attack       Yes/No         Fear Attack       Yes/No         Heart Migh Blood Pressure       Yes/No	<u></u>						Yes/N	10	EM	
Heart Infection       Yes/No         Abnormal Heart Beat       Yes/No         Sickle Cell Disease       Yes/No         20. Do you have a family history of the following:       33. Has anyone recommended you change your weight       Yes/No         Sudden Death       Yes/No         Death under Age 50       Yes/No         Heart Attack       Yes/No         Heart Attack       Yes/No         Passing out / Syncope       Yes/No         Sickle Cell Disease       Yes/No         Heart Attack       Yes/No         Passing out / Syncope       Yes/No         Sickle Cell Disease       Yes/No         Heart Midack       Yes/No         Heart Attack       Yes/No         Passing out / Syncope       Yes/No         High Blood Pressure       Yes/No	<b>NRI</b>			Hig	h Cholesterol			lo	Ξ.	31. Are you happy with your weight? Yes/No
Heart Infection       Yes/No         Abnormal Heart Beat       Yes/No         Sickle Cell Disease       Yes/No         20. Do you have a family history of the following:       33. Has anyone recommended you change your weight       Yes/No         Sudden Death       Yes/No         Death under Age 50       Yes/No         Heart Attack       Yes/No         Heart Attack       Yes/No         Passing out / Syncope       Yes/No         Sickle Cell Disease       Yes/No         Sickle Cell Disease       Yes/No         Heart Attack       Yes/No         Passing out / Syncope       Yes/No         Sickle Cell Disease       Yes/No         High Blood Pressure       Yes/No	C			Hea	art Murmur		Yes/N	lo		
Abnormal Heart Beat       Yes/No         Sickle Cell Disease       Yes/No         20. Do you have a family history of the following:       33. Has anyone recommended you change your weight       Yes/No         Sudden Death       Yes/No         Death under Age 50       Yes/No         Heart Attack       Yes/No         Heart Attack       Yes/No         Passing out / Syncope       Yes/No         Sickle Cell Disease       Yes/No         High Blood Pressure       Yes/No										
20. Do you have a family history of the following:       or diet?         Sudden Death       Yes/No         Death under Age 50       Yes/No         Heart Disease       Yes/No         Heart Attack       Yes/No         Passing out / Syncope       Yes/No         Sickle Cell Disease       Yes/No         High Blood Pressure       Yes/No						at				
Sudden Death       Yes/No         Death under Age 50       Yes/No         Heart Disease       Yes/No         Heart Attack       Yes/No         Passing out / Syncope       Yes/No         Sickle Cell Disease       Yes/No         High Blood Pressure       Yes/No		- 20	Daviau hava				Yes/N	10		
Death under Age 50     Yes/No       Heart Disease     Yes/No       Heart Attack     Yes/No       Passing out / Syncope     Yes/No       Sickle Cell Disease     Yes/No       High Blood Pressure     Yes/No		20.	Do you have			owing.	Voc/N			
Heart Disease       Yes/No         Heart Attack       Yes/No         Passing out / Syncope       Yes/No         Sickle Cell Disease       Yes/No         High Blood Pressure       Yes/No						)				34. Do you limit or carefully control what you eat? Yes/No
Heart Attack     Yes/No       Passing out / Syncope     Yes/No       Sickle Cell Disease     Yes/No       High Blood Pressure     Yes/No								-	F	Explain "Yes" answers here (Please number the answer )
Sickle Cell Disease     Yes/No       High Blood Pressure     Yes/No										
High Blood Pressure Yes/No	I			Pas	ssing out / Synco	ре	Yes/N	lo		
Martan's Syndrome Yes/No										
	L			Mar	tan's Syndrome		Yes/N	10		
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	1_									
	1									

Website: www.wheaton.edu/shs

Email: Student.Health.Services@wheaton.edu Phone: 630-752-5072 Fax: 630-752-5575

#### WHEATON COLLEGE, IL MEDICAL EXAMINATION FORM

This form will meet the medical exam requirement for general entrance and athletic participation. The medical examination must be within one year prior to start of the school year, <u>unless</u> student is an Intercollegiate Athlete, in which case the medical exam must be done 6 months or less prior to start of the school year.

TO THE EXAMINING MEDICAL PROVIDER<sup>+</sup>. Please review the student's medical history, complete the medical examination form, and comment on all abnormal answers. Please add any laboratory diagnostic exams that are age/medical history appropriate.

Name		Student ID # D M	I DF Date of Birth	
Wt.	Ht.	BMI Please use the CDC.gov BMI calc.	Pulse	B/P
LMP date:	Regular □Yes □No	How many periods in a year?	Medications:	
Vision Corrected: Uncorrected:	R 20/ L 20/	Contact Lenses: Yes   No Glasses: Yes   No	Allergies:	Food Allergies:
		Clinical Evaluation		

		C				
Check each item in appropriate column, at right. Enter "N.E." if not evaluated.	Normal	Abnormal	Musculoskeletal Exam	Musculoskeletal Exam Normal		Abnormal (Indicate L/R)
1. Appearance			C-Spine			
2. Skull, Scalp, Face, Neck, Thyroid			Thoracic, Lumbar, Sacral Spine			
3. Nose and Sinuses				L	R	
4. Mouth (tongue, gingivae, teeth)			Shoulders			]
5. Throat and Tonsils			Elbows			
6. Ears (Int. and Ext. canals)			Elbows			
7. Eyes (pupils, E.O.M., conjunctiva)			Wrists			
8. Lungs and Chest (include Breasts)			Hand/Fingers			
9. Heart (rhythm, sounds, and Murmurs. Examine in sitting, recumbent, and left recumbent positions before and after exercise.)			Hips			
10. Abdomen/Pelvis and Viscera (include hernia)			Upper Legs			
11. Endocrine System			Knees			
12. G-U System (optional for females) males: testes			Lower Legs			
13. Skin			Ankles			
14. Lymphatic Glands			Feet/Toes			
15. Neuro/Psych			Other:			

**Required:** Recommendations for physical activity for intercollegiate, intramurals, club sports, travel abroad, general education requirements, internships. (Please complete or student cannot compete/participate):

Cleared without restriction

Cleared, with recommendations for further evaluation or treatment for:

# + If this student is a NCAA intercollegiate athlete, he or she must have a sickle cell screening through blood test submitted to the Wheaton College Athletic Department.

+Intercollegiate Athletes must complete Medical Examination by a M.D. or D.O per NCAA rules and Wheaton College Athletic Department.							
+M.D., D.O., PA, or NP Signature (Circle one of the above)	Date	Phone					
Medical Providers Name (please print or use stamp):		Fax:					
A 1.1							

#### TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

#### Student: please fill out and submit form to SHS as this is part of your entrance medical requirements, even if you have not had any prior testing.

Prior Testing:	Have you had a TB skin test (PPD)?	s If yes, result:  Negative  Positive Date:				
	Have you had a TB blood test (IGRA)?  No  Yes	If yes, result:  Negative  Positive Date:				
Please answer qu answer is "YES."	estions 1-16 and provide an explanation if the	Explanation				
1. Have you ever had active TB?	been told by a doctor or healthcare provider that you	$\Box$ Y $\Box$ N				
year?	taken medication for TB? Which medication(s)? What					
3. Have you ever you from this re	had a BCG vaccine for TB? (BCG does not exempt equirement)	$\Box$ Y $\Box$ N				
	been told by a healthcare provider that your immune orking right or that you cannot fight infection? (e.g. er or illness)					
5. Have you cared disease in the p	for, or lived with, anyone diagnosed with active TB ast year?					
	ed or volunteered in a setting where TB may be more as a homeless shelter, nursing home, group home, or ast year?	$\Box$ Y $\Box$ N				
7. In what country	were you born?					
8. If you were not	born in the USA, since what year have you been in the U	/SA?				
9. Have you lived	in any other country for greater than one year? $\Box$ Y	$\Box$ N If yes, where and when?				
10. Have you trav	eled outside the USA in the past year? $\Box Y \Box N$					
If yes, please p	rovide the following information.					
Country	Length of stay (in days/weeks)	Date of return				
Country	Length of stay (in days/weeks)	Date of return				
Country	Length of stay (in days/weeks)	Date of return				
	ived a live vaccine in the past 6 weeks? (e.g. measles, a, chickenpox, or shingles)	$\Box$ Y $\Box$ N				
	ghing (3 weeks or more)					
	blood or bloody sputum					
14. Night sweats (						
15. Unexplained v	5					
	excessive fatigue?					
17. Fever of unkn	own origin?	$\Box$ Y $\Box$ N				

SHS will review this form and contact you if you need an individual plan for further testing. Testing mayinclude a PPD skin test(s) or an IGRA blood test. These services may be available through Student Health Services.

For non-SHS Medical Providers, please use TB SCREENING SUPPLEMENT FOR MEDICAL PROVIDERS (page 6) to provide additional documentation.

### IMMUNIZATIONS REQUIRED BY WHEATON COLLEGE

Please attach an official immunization report. Report must include healthcare provider signature or office stamp. Immunizations are required by the State of Illinois for all incoming students. Other immunizations are recommended by Wheaton College. Alternatively, this form may be completed in English, including month, day, and year for each immunization.

#### **\*TETANUS/DIPHTHERIA/PERTUSSIS**

3 doses required. One dose must be Tdap received within 10 years prior to term of current enrollment. At least six months required between 2nd and 3rd dose.

TETANUS OR     MONTH DAY YEAR     MONTH DAY YEAR	DIPHTHERIA, PERTUSSIS,	#1	#2	#3	#4	#5	Tdap
DIPHTHERIA, TETANUS MONTH DAY YEAR	TETANUS or						
	DIPHTHERIA, TETANUS	MONTH DAY YEAR					

#### \*MENINGITIS CONJUGATE (Menactra or Menveo or Medquadfi)

*MCV4				
Must have 1 dose on, or after, age of 16 years old	MONTH	DAY	YEAR	

#### \*M.M.R. (Measles, Mumps, Rubella)

Two doses of M.M.R. at least 28 days apart after 12 months old. Born before 1957, no immunization required.

	#1	#2
M.M.R. (MEASLES, MUMPS, RUBELLA)		
	MONTH DAY YEAR	MONTH DAY YEAR

#### IMMUNIZATIONS RECOMMENDED BY WHEATON COLLEGE

POLIO Recommended	*Please circle which	vaccine given							
OPV (oral) <u>Or</u> IPV (injected)	#1 MONTH DAY YEAR	#2 MONTH D	AY YEAR	#3	ONTH DAY YEAR	#4	H DAY YEAR	#5 Month day year	
HEPATITIS B Recommended (Three doses of vaccine OR a positive surface antibody)									
HEPATITIS B     #1     #2     #3       IMMUNIZATION     MONTH DAY YEAR     MONTH DAY YEAR     MONTH DAY YEAR					HEPATITIS SURFACE	S B ANTIBODY	MONTH DAY YEA	YEAR RESULT: 	
VARICELLA (CHICI month apart)	VARICELLA (CHICKENPOX) Recommended (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one								
HISTORY OF DISEASE YES NO OR VARICELLA ANTIBODY MONTH DAY YEAR RESULT: NON REACTIVE									
DATE <u>/</u> MM DD		IMMUNIZATIO		#1		#2 MONTH DAY YEAR			
OTHER IMMUNIZA	TIONS RECEIVED	(i.e. Hepatitis A, T	yphoid, H	IPV, Yello	w Fever, Me	ningitis B, Me	nomune, etc.)		

#1	#2	#3	#4	#5
MONTH DAY YEAR				
#1	#2	#3	#4	#5
MONTH DAY YEAR				

#### Required Medical Provider Signature Date\_\_\_\_\_

Print Name

\_\_\_\_\_Phone\_\_\_\_\_

E-mail

\_Address: \_\_\_\_

Immunization Exemption Policy By Illinois State law, a student may be exempt from immunizations for one of only two reasons: medical or religious. To request an immunization exemption form, please email Student. Health. Services@wheaton.edu. All completed forms will be reviewed by the Director of Student Health Services for approval. This is part of the entrance requirements.

Fax:

\*

#### TB SCREENING SUPPLEMENT FOR MEDICAL PROVIDERS

This page should be provided to your medical provider if a new PPD skin test has been administered or an IGRA blood test has been completed based on the information on the TB Screening Questionnaire (page 4). Student please provide this supplement to your medical provider to complete if they administered/performed one of these tests. If you have prior testing or TB Treatment, please provide the official report(s).

Patient Name		/	_/
Last	First	Date of birth	Student ID number
TST/PPD			If positive, refer to
Date obtained /		/ /	_ CDC.gov rubric.
Month Day	Year Mon	th Day Year	Progress to IGRA
Results	Interpretation		testing
Interferon Gamma Release A	ssay (IGRA)		If IGRA positive,
Date obtained /	/ (specify method)	: Y QFT Y T-Spot	progress to chest x-ray
Month	Day Year		
Result: negativepost	itiveindeterminate /borderline	e Please	attach
		report tran	nslated into
		Engl	ish.
Chest X-ray: (Required if IG			
Date of chest x-ray / Month D	/ Result: Υ normal Υ al	bnormal Please	attach report translated into English
Medication Section:			
	e medication because of the positiveresults?	No <u>Yes</u>	
If yes, did they accept mo	edication? NoYes		
Date Started:	s) were prescribed? / /Date Ended:	/ /	
Date Started.		/ /	_

#### **Additional Notes:**

- 1. If BCG was received, an IGRA is preferred to a PPD.
- 2. If immune deficient, testing may be falsely negative and there is greater risk of progression from LTBI to active disease
- 3. If a live vaccine was recently received or patient is ill, consider delaying IGRA testing until 4-6 weeks after vaccination or illness to avoid a false positive result.
- 4. If PPD positive complete IGRA. If IGRA is positive, send chest x-ray results

#### **Health Care Provider**

Name _	Signature		
Address			
_			
	Fax	Phone	

# WHEATON COLLEGE STUDENT HEALTH SERVICES MEDICAL FORMS

MyWheaton.edu email is the official communication of Wheaton College. Please be sure to check your Wheaton College email regularly for updates on your submitted health requirements and other college announcements.						
Form	Form	Form	Form	Form		
Page 1-2 Medical History	Page 3 Medical Examination	Page 4 Tuberculosis Screening Questionnaire	Page 5 Required Immunizations and Recommended Immunizations	Page 6 Tuberculosis Screening Supplement for Medical Providers*		
Filled out by student* Complete page two ONLY if student athlete *Parent is to fill out Minor Consent if student is a minor on August 1st or later.	Filled out by M.D., D.O., NP, or PA <b>*If you are an</b> <b>Intercollegiate Athlete,</b> <b>the Medical</b> <b>Examination must be</b> <b>completed and signed</b> <b>by a MD or DO (or NP</b> <b>in full practice</b> <b>authority states) per</b> <b>NCAA rules and</b> <b>Wheaton College</b> <b>Athletic Department</b> <b>within six months of the</b> <b>start of school year</b>	Filled out by student	Filled out by Medical Professional with office stamp OR can submit official record of immunizations from office with office stamp	*If necessary Filled out by Medical Professional with office stamp* *Required <u>only</u> if MD, PA, or NP orders TB Test.		
2 easy way to submit your forms securely:						
Preferred Method: Submit your form: MyChart. All com through MyChart. Your MyChart acce	: s through Northwestern munication will be done	Incomplete Student Health Services Requirements: If health entrance forms are not completed and submitted by the deadline (refer to email from SHS for your deadline), a late fee of \$100.00 and/or a registration hold may be placed on the student's account.				
	Student Health lege Ave, Wheaton, IL d by your deadline	Phone: 630.752.5072 Extension requests for submission of entrance medical requirement forms must be made from student's Wheaton College email 2 weeks before your deadline and are approved at the discretion of the SHS staff.				