BOISE STATE UNIVERSITY
HEALTH SERVICES

New Patient Health History

Name:_____

University ID:_____

Date of Birth: _____/_____/_____ **Sex:** M: ☐ F: ☐

Marital Status: Single: ☐ Married: ☐ Divorced: ☐

Long-term illness or condition, or any problem requiring regular treatment/care? (stomach, heart, headaches, weight, mental health/depression, blood pressure, asthma, etc.) None: ☐

If yes, please list:_____

_____

_____

Allergies to Medications: None: ☐

If yes, please list:_____

_____

Other Allergies: Seasonal: ☐ Other: ☐ None: ☐

If yes, please list:_____

_____

Current Medications *(name, dose)*: None: ☐

Prescriptions (Includes Birth Control):_____

_____

_____

Over the counter/herbal:_____

_____

Past history of serious illness or trauma *(broken bones, concussions, pneumonia, etc.)*: None: ☐

If yes, please list:_____

_____

Has anyone in your family had: cancer, heart disease, high blood pressure, diabetes, thyroid problems, mental illness, or <u>other</u> inherited conditions? None: ☐

If yes, please list relative & condition:_____

_____

_____

_____

Past surgeries and/or hospitalizations (please list with date): _____

_____

_____

Tobacco/Nicotine Use: Never: ☐ Past: ☐ Current: ☐

Type: Cigarettes/Cigar/Pipe: ☐ Smokeless: ☐ Vaping: ☐

Quit when?: _____

How many?:_____ Per:_____

How long?: _____

Alcohol Use:

How many drinks do you average in a day? _____ A week? _____

How often do you binge drink (more than 4-5 drinks in one night?

_____

Street/Recreational/Illicit Drug Use: No: ☐ Yes: ☐

IV Drug Use: No: ☐ Yes: ☐

What kind?: _____

How much?: _____

How long?: _____

Screening for anxiety and depression: Over the past **2 weeks**, how often have you been bothered by any of the following items?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	*0*	*1*	*2*	*3*
2. Not being able to stop or control worrying	*0*	*1*	*2*	*3*
3. Little interest or pleasure in doing things	*0*	*1*	*2*	*3*
4. Feeling down, depressed, or hopeless	*0*	*1*	*2*	*3*

Females Only: # of pregnancies: _____ # of live births: _____

Menses regular? No: ☐ Yes: ☐

First day of last menstrual period? _____/_____/_____

Signature: _____

Date:_____/_____/_____

<<<<< CONFIDENTIAL MEDICAL INFORMATION >>>>

Please retain a copy for program application

Boise State University Athletic Training Program (ATP)

HEALTH PHYSICAL

Name _____ Date _____

Current Street Address: _____

City _____ State _____ Zip Code _____

Date of Birth _____ Age _____ Year in school _____

---

corrected uncorrected

HEIGHT:_____(in.) WEIGHT:_____(lbs.) VISION: R_____/_____ L_____/_____

BLOOD PRESSURE: _____ GENDER: male female

GENERAL HEALTH EXAM	NORMAL	ABNORMAL FINDINGS
EYES		
EARS, NOSE, THROAT		
CARDIOVASCULAR		
ABDOMEN		
GENITALIA: hernia		
SKIN		

MD's INITIALS _____

COMMENTS: _____

_____

ORTHOPEDIC EXAM	NORMAL	ABNORMAL FINDINGS
NECK		
BACK		
RIGHT SHOULDER		
LEFT SHOULDER		
RIGHT ELBOW		
LEFT ELBOW		
WRIST/HANDS		
RIGHT HIP		
LEFT HIP		
RIGHT KNEE		
LEFT KNEE		
RIGHT ANKLE		
LEFT ANKLE		
FEET		
NEUROMUSCULAR		

PROVIDER COMMENTS or RECOMMENDATIONS: _____

_____

_____

FOLLOW-UP PROCEDURES REQUIRED Yes No

ATP PARTICIPATION APPROVED Yes No

DOCTOR'S SIGNATURE: _____ Date:_____