Return by July 31st to:

Student Health Center
204 W. Washington Street
Lexington, VA 24450
Fax: (540) 458-8404
studenthealth@wlu.edu
Phone: (540) 458-8401

WASHINGTON AND LEE UNIVERSITY

Lexington, Virginia 24450-2116

REPORT OF MEDICAL HISTORY

This form is to be reviewed and signed by your healthcare provider

LAST NAME (Print) _____ FIRST NAME _____ MIDDLE _____ GENDER _____ DATE OF BIRTH: ____/____/____ M D Y

HOME STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____ STUDENT'S PHONE NUMBER _____

CLASS: UG First Yr ☐ UG Transfer/Exchange ☐ Law 1L ☐ Law Transfer/Exchange ☐ PREVIOUSLY ENROLLED HERE? YES ☐ NO ☐

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____ ADDRESS _____ PHONE NUMBER _____

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FAMILY HISTORY

	SEX	AGE	OCCUPATION	STATE OF HEALTH	AGE/CAUSE OF DEATH
PARENT					
PARENT					
SIBLINGS					

HAVE ANY RELATIVES HAD THE FOLLOWING?:

	YES	NO	RELATIONSHIP
DIABETES			
HEART DISEASE, STROKE			
CANCER			
SICKLE CELL ANEMIA/TRAIT			
TUBERCULOSIS			
ALCOHOL/DRUG PROBLEM			
DEPRESSION			

PERSONAL HISTORY—PLEASE ANSWER ALL QUESTIONS AND ELABORATE ANY "YES" ANSWERS ON SUPPLEMNTAL FORM

Have You Had?	Yes	No
Chicken Pox		
Mononucleosis		
Menstrual problems		
Head injury/concussion		
Epilepsy/seizures		
Migraine headaches		
Tumor, cancer		
Diabetes		

Have You Had?	Yes	No
Dental problems		
Eye problems		
Ear, nose, throat problems		
Asthma, allergies		
Food/drug allergy (List below)		

Have You Had?	Yes	No
Anxiety or depression		
Sleep difficulty		
Eating disorder		
Alcohol/drug problem		
Learning disability		
ADD/ADHD		
Other psychological or psychiatric problem		

Have You Had?	Yes	No
Disease/injury of bones or joints		
Back problems		
Heart problems		
Lung problems		
Stomach/intestinal problems		
Liver/kidney problems		
Sickle Cell Anemia or Trait		

	YES	NO
Do you drink alcohol? How often? How many drinks per occasion?		
Do you use cigarettes, e-cigarettes or smokeless tobacco products?		
Do you take any medications on a regular basis? (List on supplemental medication form)		
Have you received treatment or counseling for alcohol or drug abuse, an eating disorder, depression, or other emotional problem? Have you been hospitalized or received in-patient care for any of these conditions? (Give details on next page)		
Have you had any significant illness or injury for which you have been treated, hospitalized or had your physical activity restricted (other than already noted)? (Give details on next page)		

Student's Signature _____ Physician's Signature (Acknowledging Review) _____ Date _____

Please continue to next page

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REPORT OF PHYSICAL EXAM

This form is to be completed and signed by your healthcare provider

TO THE EXAMINING CLINICIAN: Please review the student's history, complete the physical examination, and comment on any abnormal findings. **FOR ALL PROSPECTIVE NCAA ATHLETES:** The supplemental Pre-Participation History Form and clearance for NCAA athletic participation (below) MUST be completed within 6 months of the start of the school year and submitted for review at least 2 weeks prior to arrival. Screening for Sickle Cell Trait is REQUIRED for NCAA athletic participation—please attach results.

_____ DOB:_____ Sex: M ☐ F ☐ Other:_____
LAST NAME (Print) FIRST NAME MIDDLE

Blood Pressure _____/_____ Pulse _____ Height _____ inches Weight _____ pounds BMI_____

Dip Urinalysis _____ or N/A ☐ HCT or HGB _____ or N/A ☐

Sickle Cell Screen _____ (**REQUIRED ONLY** for NCAA athletic participation—please attach results)

	Normal	Abnormal Findings
Appearance (including Marfan stigmata)		
Head, Ears, Nose, or Throat		
Eyes		
Respiratory		
Cardiovascular		
Gastrointestinal		
Genitourinary		
Musculoskeletal		
Metabolic/Endocrine		
Neuropsychiatric		
Skin		

Is the patient now under treatment for any medical or emotional condition? YES ☐ NO ☐

Is the patient currently taking any medication on a regular basis? YES ☐ NO ☐

If yes, please list medications and dose on medication sheet

Is there a loss or seriously impaired function of any organ? YES ☐ NO ☐

Cleared for all NCAA sports participation without restriction? N/A ☐ YES ☐ NO ☐

If NO, explain restrictions or further evaluation needed: _____

Do you have any further recommendations for the care of this student? YES ☐ NO ☐

Explain: _____

HEALTHCARE PROVIDER NAME _____

ADDRESS_____

_____

PHONE _____ FAX _____

SIGNATURE _____ DATE _____

(Rev. 2/23)

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SUPPLEMENTAL MEDICATION AND HISTORY FORM

This form is to be reviewed and signed by your healthcare provider

Name _____ Class Year _____ ☐ UG ☐ LAW
Last First Middle

Date of Birth: _____/_____/_____

LIST MEDICATION NAME, DOSE, AND HOW YOU ARE TAKING IT

1.
2.
3.
4.
5.
6.
7.

LIST ONGOING MEDICAL/PSYCHOLOGICAL CONDITIONS AND SIGNIFICANT PAST MEDICAL HISTORY

1.
2.
3.
4.
5.
6.
7.

ADDITIONAL INFORMATION FOR OUR HEALTH CARE TEAM

_____

_____

_____

_____

Physician signature acknowledging review Date

(Rev. 2-23)