THE FLORIDA ATLANTIC UNIVERSITY **DEPARTMENT OF MUSIC MARCHING OWLS MEDICAL HISTORY QUESTIONNAIRE** (THIS FORM TO BE COMPLETED BY INCOMING STUDENT)

LAST NAME:	FIRS7	Г:	MIDDLE:
PERMANENT STREET ADDRESS:			
CITY:	STATE:		ZIP:
TELEPHONE:	DATE OF BI	RTH: _	GENDER:
I. General Questions	Circle	One	List or Explain:
1. Do you have any allergies?	Yes	No	
2. Do you take medication daily?	Yes	No	
(Include birth control pills, prescription and	d over the cou	unter r	medications and nutritional supplements, etc.)
3. Do you wear contact lens or glasses?	Yes	No	
4. Do you wear dental appliances?	Yes	No	
5. Do you wear a hearing aid?	Yes	No	
6. Do you have diabetes?	Yes	No	
7. Do you have any chronic illnesses or	Yes	No	
medical problems?			
8. Have you ever suffered from exhaustion	Yes	No	
or heat stroke?			
9. Have you ever been instructed by a	Yes	No	
physician to reduce or limit physical activit	ty?		
10. Has any family member died under the	Yes	No	
age of 50?			
11. Have you ever had any hospitalizations	Yes	No	
or slept overnight in the hospital?			
12. Have you ever had any surgery?	Yes	No	
13. Have you ever had an illness that lasted	l Yes	No	
longer than a week?			

FAU MARCHING OWLS - MEDICAL HISTORY QUESTIONNAIRE - PAGE 2 of 4

II.	Cardiac
	Curuiuc

1. Have you ever been told you have high blood pressure?	Yes No	
2. Have you ever been told you have a murmur?	Yes No	
3. Have you ever fainted or passed out while exercising?	Yes No	
4. Has any family member had any heart problems	Yes No	
before the age of 50?		
5. Have you or anyone in your family been told they have Marfan's		
Syndrome?	Yes No	
6. Have you ever been told you have an irregular heart beat	Yes No	
or other heart problems?		
7. Have you ever been evaluated for chest pain?	Yes No	
If any Yes answers, please explain:		

III. Respiratory

1. Do you have asthma?	Yes	No
2. Do you have a history of childhood asthma?	Yes	No
3. Do you have any trouble with your lungs?	Yes	No
4. Do you have any difficulty with shortness of breath or coughing spells?	Yes	No
5. Do you have wheezing or coughing after exercise?	Yes	No
6. Do you have any history of taking asthma medications?	Yes	No
(pills or inhalers)		
7. Do you have a history of exposure to tuberculosis or a positive skin test?	Yes	No
If any Yes answers, please explain:		

IV. Neurologic		
1. Do you have a problem with frequent headaches, blurry vision or dizziness?	Yes	No
2. Have you ever been knocked out?	Yes	No
3. Have you ever had a concussion?	Yes	No
4. Have you ever had a seizure?	Yes	No
5. Do you currently have seizures or epilepsy?	Yes	No
6. Do you have numbness, tingling or weakness in your arms or legs?	Yes	No
If any Yes answers, please explain:		

FAU MARCHING OWLS - MEDICAL HISTORY QUESTIONNAIRE - PAGE 3 of 4

V. Musculoskeletal

1. Do you have any neck problems?	Yes	No
2. Do you have any back problems?	Yes	No
3. Have you ever had a back or neck injury?	Yes	No
4. Do you have any joint problems (shoulders, elbows, hips, knees,	Yes	No
hands, fingers, ankles, toes)		
5. Do you have any incompletely healed injuries?	Yes	No
6. Have you ever had a fracture or a cast?	Yes	No
7. Do you have arthritis?	Yes	No
If any Yes answers, please explain:		

FAU MARCHING OWLS - MEDICAL HISTORY QUESTIONNAIRE - PAGE 4 of 4

Signature and Release

"I have filled out this information questionnaire truthfully and to the best of my knowledge. I understand that failure to provide any information requested releases Florida Atlantic University, the Department of Music, Marching Owls Staff and consulting physicians from legal responsibility regarding recurrences or complication of any conditions not listed here.

I also permit the examining physician to release a copy of my completed Marching Owls physical exam form to the Department of Music and the Director of the Marching Owls for their records."

Signed:		Date:	
	(student)		

Received by: _____ Date: _____