

PERSONAL HEALTH HISTORY

1. Hospitalizations. Describe nature of illness or injury, where and how long hospitalized, and treatment, including surgery:

2. Childhood diseases-mumps, chicken pox, whooping cough, measles. Give age of occurrence for each:

3. Other diseases-rheumatic or scarlet fever, polio, kidney disease, TB, diabetes, cancer, heart disease. Give age of occurrence, complications, treatment:

4. Disabilities or deformities. Describe and state whether congenital or acquired:

5. Allergies. Food or drug reactions. Hay fever, asthma. Hives or rashes?

6. Have you experienced any of these conditions:

	(√)		(√)
Headache		Poor Appetite	
Sinusitis		Excessive weight loss or gain	
Earache		Intolerance for any foods	
Difficulty in hearing		Diarrhea	
Dizziness		Constipation	
Nosebleeds		Irregularities in urination	
Bleeding gums		Excessive thirst	
Sore throat		Anemia	
Hoarseness		Easy bruising	
Speech defects		Prolonged bleeding after cuts	
Chest pain		Numbness or tingling of extremities	
Shortness of breath		Nervousness	
Swelling of ankles, feet or legs		Convulsions or tremors	
Varicosities		Difficulties in swallowing	

Comments on any of the above:

7. Have you been treated for gonorrhea or syphilis? _____

8. Glasses or contact lens _____ How long worn? _____

For reading or distance? _____ Does vision blur? _____

Is there a family history of blindness or glaucoma? _____

9. When was last dental checkup? _____

What dental procedures have been performed? _____

10. Smoking? _____ How much per day? _____ Age when started? _____

11. Alcoholic beverages? _____ How often? _____

12. Drug Use? _____

Describe: _____

13. Do you take any medication regularly? _____

Describe: _____

14. Menstrual history: Age when started: _____ Frequency: _____ Duration: _____

Pain: _____

15. Regular hours of sleep? _____ Insomnia? _____

16. Usual exercise: _____ Frequency: _____

Student Name: _____

To be completed by Health Care Provider

Name _____

MEDICAL EXAMINATION

(Please indicate normal by √)

PHYSICAL STATUS	INITIAL EXAMINATION Date:		PHYSICAL STATUS	INITIAL EXAMINATION Date:	
General			Noses and Sinuses		
Height			Septal Deviation		
Weight			Sinus Tenderness		
Pulse			Inflammation		
Respiration			Smell		
Blood Pressure			Mouth		
Face			Lips		
Symmetry			Buccal Mucosa		
Texture			Gums and Teeth		
Lesions			Palate		
Eruptions			Tongue		
Hair Distribution			Pharynx		
Involuntary Movements			Throat		
Head			Tonsils		
Proportion to Body			Neck		
Scalp Condition			Nodes		
Eyes	R	L	Trachea		
Vision (Snellen)			Thyroid		
Corrected			Thorax		
Visual Fields			Shapes, Size, Symmetry		
Lacrimal System			Breasts	R	L
Conjunctiva			Size and Symmetry		
Cornea and Lens			Masses or Nodules		
Pupils			Discharge from Nipples		
Retina			Lungs		
Ears			Resonance		
Hearing			Breath Sounds		
Canal			Diaphragmatic Movement		
Tympanic Membrane					

Heart		Genitalia	
Rate and Rhythm		Male: Penis	
Heart Sounds		Scrotum	
Murmurs and Thrills		Hernias	
Abdomen		Prostate	
Appearance/Scars		Female: External Genitalia	
Bowel Sounds		Vagina	
Tenderness		Cervix	
Masses		Uterus	
Palpable Organs		Rectovaginal Exam	
Peripheral Vascular		Anus and Rectum	
Pulses		Neurological	
Edema		Reflexes	
Veins		Motor System	
Musculoskeletal		Sensory System	
Gait		Mental Status	
Posture			
Joints & Range of Motion			

Please attach a copy of results of required studies:

Titers for measles, mumps, rubella (MMR) and varicella

Boosters required for non-immune status
 Titer for Hepatitis (if series completed)
 CBC
 Comprehensive Metabolic Panel
 Urinalysis

IMMUNIZATION RECORD

Tetanus: (date last received or unknown)

Hepatitis series/waiver:
 PPD (1 month prior to entrance):
 Chest X-Ray (only if PPD is positive):

Summary, Remarks, and Recommendations: _____

Health Care Provider's
 Signature: _____

Date: _____