

LAST NAME	FIRST NAME:	INITIAL:	MARITAL SATUS SINGLE DIVORCED MARRIED NO CHILDREN
-----------	-------------	----------	---

HEALTH RECORD

ADDRESS: (STREET, CITY, ZIP)

TELEPHONE: WHAT ARE YOU STUDYING TO BE?

NAME AND ADDRESS OF FAMILY DOCTOR/CLINIC: STUDENT ID NUMBER:

DATE OF BIRTH: LAST HIGH SCHOOL ATTENDED (NAME, CITY, STATE):

UNDERLINE DISEASE YOU HAVE HAD:
 ANEMIA NERVOUS BREAKDOWN
 ASTHMA PLEURISY
 APPENDICITIS PNEUMONIA
 BLACKOUTS POLIO
 BRONCHITIS RHEUMATIC
 CHICKEN POX RHEUMATIC FEVER
 DIABETES SCARLET FEVER
 DIPHTHERIA SMALL POX
 EPILEPSY SICKLE CELL
 HAY FEVER SINUSITIS
 EAR PROBLEM TONSILITIS
 HEART TROUBLE TYPHOID FEVER
 JAUNDICE THYROID DISORDER
 KIDNEY PROBLEM TUBERCULOSIS
 LARYNGITIS ULCER
 MUMPS VARICOSE VEINS
 MEASLES WHOOPING COUGH

FAMILY HISTORY: UNDERLINE AND NOTE
 RELATIVE
 TUBERCULOSIS
 NERVOUS BREAKDOWN
 DIABETES
 CANCER

WHAT VACCINATIONS OR TESTS HAVE YOU HAD? WHAT YEARS?
 SMALL POX TETANUS CHEST X-RAY POLIO

SERIOUS ILLNESSES:

OPERATIONS:

LIST YOUR MAJOR INJURIES:

ALLERGIES:

A complete physical examination including labs is required every two (2) years unless otherwise Specified by affiliated hospital contracts.

PHYSICAL EXAM:	DATE:	ADDITIONAL DATA – SUMMARY - RECOMMENDATIONS
GENERAL APPEARANCE:	HEIGHT WEIGHT	
POSTURE		
SKIN:	BACK:	
EYES: PERLA:	RETINA:	
EARS: R L	HEARING:	
NOSE AND THROAT:		
TEETH: GUMS: DENTAL HYGIENE		<input type="checkbox"/> FREE OF COMMUNICABLE DISEASES – DOES NOT CREATE HAZARD TO SELF OR OTHERS
GLANDS: THYROID		<input type="checkbox"/> APPROVED AND RECOMMENDED FOR MEDICAL ASSISTING PROGRAM
LUNGS:		<input type="checkbox"/> NO APPROVED – SEE ABOVE
HEART:		<input type="checkbox"/> APPROVED PENDING AS ABOVE
PULSE:		EXAMINED BY: ,MD
ABDOMEN:		NURSE PRACTITIONER
ENDOCRINE SYSTEM:		LICENSE NO:
NERVOUS SYSTEM:		ADDRESS & PHONE NO.
BLOOD PRESSURE:		

STUDENT'S NAME (Print) _____ Student ID #: _____

	Date	Results	Dr. Signature/Address/Phone Number
(*Required for MA Program)			
*Tuberculin Skin Test	_____	_____	_____
OR			_____
Chest X-ray			_____
Rubella (Measles)	_____	_____	_____
(Titer/Vaccine)			_____

Varicella (Chicken Pox)	_____	_____	_____
(Titer/Vaccine)			_____

*Rubella	_____	_____	_____
(Titer/Vaccine)			_____

*Hepatitis B	_____	_____	_____
(Titer/Vaccine)	_____	_____	_____

*Mumps	_____	_____	_____
(Titer/Vaccine)			_____

Polio (All students enrolled in health related courses are encouraged to ascertain that they are immune to poliomyelitis.)

_____	_____	_____
_____	_____	_____

*Diphtheria/Tetanus (Series of two, one month apart. Boosters in one year, then repeat in ten years. If you had series as a child, All you need is the booster).

_____	_____	_____

*Drug Screen (with Lab results) _____

IF THE TITER IS NEGATIVE, A VACCINE WILL BE REQUIRED. THEN A REPEAT TITER AS DESIGNATED PER MEDICAL PROTOCOL.

COPIES OF ALL LABORATORY REPORTS ARE REQUIRED.