



**Form B: Physical Exam & Health History**

*This section to be completed by the student, & reviewed by the HCP. Please use ink and print clearly.*

Name \_\_\_\_\_ Program/Yr. \_\_\_\_\_ Student ID \_\_\_\_\_

Gender:  M  F Date of Birth: \_\_\_/\_\_\_/\_\_\_ Telephone Number: \_\_\_\_\_

Allergies (drugs/food): \_\_\_\_\_

Medications currently taking: \_\_\_\_\_

**Place a check mark if you currently or have ever had any of the following:**

HEAD		GASTROINTESTINAL		BLOOD DISORDER	
<input type="checkbox"/>	Major dental problems	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Dizziness or Fainting	<input type="checkbox"/>	Recent changes in appetite	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	Encephalitis	<input type="checkbox"/>	Recent changes of bowel habits	<input type="checkbox"/>	Sickle Cell
EYES/EARS/NOSE/THROAT		<input type="checkbox"/>	Recent constipation	<input type="checkbox"/>	Lymphoma
<input type="checkbox"/>	Eye trouble	<input type="checkbox"/>	Frequent diarrhea	<input type="checkbox"/>	Other
<input type="checkbox"/>	Wear glasses	<input type="checkbox"/>	Digestive disorder	MENTAL HEALTH	
<input type="checkbox"/>	Wear contact lenses	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	Frequent Nightmares
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Recurrent emesis (vomiting)	<input type="checkbox"/>	Trouble concentrating
<input type="checkbox"/>	Ear trouble	<input type="checkbox"/>	Gastric or duodenal ulcer	<input type="checkbox"/>	Cry often
<input type="checkbox"/>	Hearing problem	<input type="checkbox"/>	Hemorrhoids/Rectal fissures	<input type="checkbox"/>	Feeling of Depression
<input type="checkbox"/>	Frequent nosebleeds	<input type="checkbox"/>	Other ano-rectal disorders	<input type="checkbox"/>	Tendency to worry
<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Memory Loss
<input type="checkbox"/>	Frequent sore throat	<input type="checkbox"/>	Intestinal worms	<input type="checkbox"/>	Metal Health Disorder
ENDOCRINE		<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	Feelings of loneliness
<input type="checkbox"/>	Hypothyroid	<input type="checkbox"/>	Black bowel movements	<input type="checkbox"/>	Considerable nervousness
<input type="checkbox"/>	Hyperthyroid	<input type="checkbox"/>	Vomiting blood	<input type="checkbox"/>	Difficulty Sleeping
<input type="checkbox"/>	Diabetes mellitus	<input type="checkbox"/>	Intestinal inflammation	<input type="checkbox"/>	Considered Suicide
CHEST/HEART/LUNGS/VASCULAR		<input type="checkbox"/>	Gall bladder disease	<input type="checkbox"/>	Require use of Sleeping aids
<input type="checkbox"/>	Breast disease or masses	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Other
<input type="checkbox"/>	Chest Pain/Pressure	GENITOUINARY		ADDITIONAL MEDICAL HISTORY	
<input type="checkbox"/>	Heart Disease/Murmur	<input type="checkbox"/>	Urine contains : Blood / Albumin / Sugar	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	Unusual fatigue
<input type="checkbox"/>	Rapid or irregular pulse	<input type="checkbox"/>	Bladder disease	<input type="checkbox"/>	Frequent Colds
<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	Serious illness
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	Sexual Problems
<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	Genital disorder	<input type="checkbox"/>	Skin disorder/infections
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Frequent urinary tract infection	<input type="checkbox"/>	Unexplained weight gain or loss
<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	Other	<input type="checkbox"/>	Other
<input type="checkbox"/>	Night Sweats	FEMALES ONLY		SURGICAL HISTORY	
<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	Abnormal pap smear	<input type="checkbox"/>	Appendectomy
<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Ovarian cysts	<input type="checkbox"/>	Gall Bladder
<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Pelvic inflammatory disease ( PID )	<input type="checkbox"/>	Pelvic Surgery
<input type="checkbox"/>	Coughing up Blood	<input type="checkbox"/>	Pregnancy: G P	<input type="checkbox"/>	Cesarean Section
INFECTIOUS DISEASE		<input type="checkbox"/>	Painful menses ( dysmenorrhea )	<input type="checkbox"/>	Tonsillectomy
<input type="checkbox"/>	Ambiasis	<input type="checkbox"/>	Fibrocystic disease	<input type="checkbox"/>	Other
<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	Other		
<input type="checkbox"/>	Coccidiomycosis ( Valley Fever )	MUSCULOSKELETAL/NEUROLOGICAL		SOCIAL HISTORY	
<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Smoke Tobacco
<input type="checkbox"/>	Histoplasmosis	<input type="checkbox"/>	Chronic muscle pain	<input type="checkbox"/>	Alcohol Use
<input type="checkbox"/>	Intestinal Parasitic Infection	<input type="checkbox"/>	Spine problem, e.g., disc or vertebrae	<input type="checkbox"/>	Recreational Drug Use
<input type="checkbox"/>	Malaria	<input type="checkbox"/>	Swollen of painful joints/extremities	<input type="checkbox"/>	Other
<input type="checkbox"/>	Measles / Mumps / Rubella	<input type="checkbox"/>	Bone infection		
<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	Amputation	CONDITIONS THAT MAY NOT BE LISTED:	
<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	Speech defect		
<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Cluster headache		
<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	Migraine headaches		
<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	Paralysis , tremors , muscle weakness		
<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Neuralgia or numbness		

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date \_\_\_\_\_

Provider's name



## Form B: Physical Examination & Health History

*To be completed by the physician/healthcare provider.  
This can be no more than 6 months old.*

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Program/Yr \_\_\_\_\_  
Last First Middle

BP (sitting) \_\_\_\_/\_\_\_\_ Pulse: \_\_\_\_\_ Respirations: \_\_\_\_\_ Gender: M  F

Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Vision: R \_\_\_\_/\_\_\_\_ L \_\_\_\_/\_\_\_\_ Corrected  Uncorrected

EXAMINATION	NORMAL (Please Check)	ABNORMAL (Please Check)	DESCRIPTION
<b>GENERAL:</b> Posture, Gait, Speech, Appearance			
<b>HEAD:</b> Hair, Symmetry, Tenderness			
<b>EYES:</b> Lids, Sclera, Conjunctiva, Muscles.			
<b>EARS:</b> Pinna, Canal, Drum, Hearing			
<b>NOSE:</b> Septum, Obstruction, Mucosa			
<b>MOUTH/THROAT</b> Breath, Lips, Teeth, Tongue, Pharynx.			
<b>NECK:</b> Thyroid, Motion, Trachea, Veins			
<b>LYMPHATICS:</b> Cervical, Supraclavicular, Axillary			
<b>CHEST/LUNGS</b> Symmetric, Percussion, Excursion....			
<b>CARDIOVASCULAR:</b> PMI, Rate, Rhythm, Sound, Murmur...			
<b>ABDOMEN:</b> Tenderness, Organs, Hernia, Masses..			
<b>MUSCULOSKELETAL:</b> Back, Upper extremities, lower.....			
<b>SKIN:</b> Birthmarks, Rashes, Scars, Texture			
<b>NEUROLOGIC</b> DTR's, Biceps, Triceps, Patella, ETC			
<b>MENTAL STATUS:</b> ALOCx3, Affect, Judgment, ETC.....			

Limitations or restrictions: \_\_\_\_\_

Findings: \_\_\_\_\_

Please describe any significant emotional problems: \_\_\_\_\_

Are there any recommendations for continued medical care? Yes  No

If yes, please explain: \_\_\_\_\_

Healthcare Provider Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Address or Stamp of Healthcare Provider: