Medical Information Form

Please fill out section 1 and 2.
Section 3 must be completed by your physician.

1.) PERSONAL INFORMATION

ATTENDANCE (check one)
❑ Full-time
❑ Part-time

HOUSING (check one)
❑ Residence Hall
❑ Commuter

ENROLLMENT YEAR
❑ Fall ______________
❑ Spring ______________

Name ____ Sex: ❑ Male ❑ Female
LAST FIRST MIDDLE

Address ____
STREET CITY STATE ZIP

SSN# ____________________ E-Mail ____________________ Marital Status ____________

Phone Number (_____) _______ - _____________ Date of Birth ____________________

Name of Parent or Guardian ______________________________ Phone Number (_____) ______ - __________

Address of Parent or Guardian ____

2.) HEALTH HISTORY

FAMILY MEDICAL HISTORY: Have any of your relatives had any of the following diseases/disorders? If yes, please explain relationship to you.

	Yes	No	Relationship
Epilepsy	❑	❑	______________
Cancer	❑	❑	______________
Diabetes	❑	❑	______________
Tuberculosis	❑	❑	______________
Heart Disease	❑	❑	______________
Mental Illness	❑	❑	______________
Migraine Headaches	❑	❑	______________

PERSONAL MEDICAL HISTORY: Have you ever experienced any of the following? If yes, give approximate age.

	Yes	No	Age
Mumps	❑	❑	_____
Anemia	❑	❑	_____
Asthma	❑	❑	_____
Malaria	❑	❑	_____
Measles	❑	❑	_____
Diabetes	❑	❑	_____
Jaundice	❑	❑	_____
Pneumonia	❑	❑	_____
Diphtheria	❑	❑	_____
Appendicitis	❑	❑	_____
Tonsillitis	❑	❑	_____
Convulsions	❑	❑	_____
Chicken Pox	❑	❑	_____
Tuberculosis	❑	❑	_____
Heart Disease	❑	❑	_____
Draining Ears	❑	❑	_____
Scarlet Fever	❑	❑	_____
Typhoid Fever	❑	❑	_____

	Yes	No	Age
Impaired Sight	❑	❑	_____
Whooping Cough	❑	❑	_____
Rheumatic Fever	❑	❑	_____
Emotional Illness	❑	❑	_____
Mononucleosis	❑	❑	_____
Use of Tobacco	❑	❑	_____
Use of Drugs	❑	❑	_____
Use of Alcohol	❑	❑	_____
Regular use of Tranquilizers	❑	❑	_____
Regular use of Diet Pills	❑	❑	_____

List any Major Injuries: ____________________

List any Allergies: ____________________

List any other Major Illnesses: ____________________

List any surgeries you have undergone in the last 5 years: ____________________

3.) PHYSICAL EXAMINATION

The following sections must be completed by your physician.

PHYSICIAN: Please give the following about the applicant.

Measurements: Height________________ Weight ________________

Blood Pressure: ____________________ / ____________________

Vital Signs: Pulse Rate ____________ Temperature ____________

CLINICAL EVALUATION: (Describe every abnormality in the space provided below.)

Head, Face, Neck	❑ Normal	❑ Abnormal
Thyroid	❑ Normal	❑ Abnormal
Scalp	❑ Normal	❑ Abnormal
Eyes	❑ Normal	❑ Abnormal
Ears	❑ Normal	❑ Abnormal
Nose and Sinuses	❑ Normal	❑ Abnormal
Mouth, Teeth, Throat	❑ Normal	❑ Abnormal
Chest and Lungs	❑ Normal	❑ Abnormal
Abdomen	❑ Normal	❑ Abnormal
Extremities	❑ Normal	❑ Abnormal
Skin	❑ Normal	❑ Abnormal
Neurological	❑ Normal	❑ Abnormal
Muscular System	❑ Normal	❑ Abnormal
Endocrine	❑ Normal	❑ Abnormal
Genitalia	❑ Normal	❑ Abnormal
Breast Exam	❑ Normal	❑ Abnormal

Explanations: ____

____

TEST RESULTS: (Must be complete and up to date)

Results of PPD Skin Test (Day & Year)

(Chest X-Ray required for positive PPD)

HCT ________________________________

Urinalysis________________________________

Results: ____

IMMUNIZATION: (Each applicant must have the following immunizations up to date)

Initial MMR Date (Month & Year)________________

(A Measles Titre is required if patient has had measles)

MMR Booster Date (Month & Year)________________

Tetanus (Month & Year) ________________

Poliomyelitis Sabin (Month & Year) ________________

Results: ____

MISCELLANEOUS MEDICAL INFORMATION:

Are you personally acquainted with the applicant's medical history? ❑ Yes ❑ No

List any known allergies, including drug sensitivities:________________________________

____

Is the applicant now receiving any medication that you advise continuing? ________________

____

Is there any reason that the applicant should be limited in a regular educational program? ❑ Yes ❑ No

Has the applicant ever been restricted in a physical program before? ❑ Yes ❑ No Why? ____________

____

Are there any additional problems which should be called to our attention?________________

____

Females only: Are menstrual periods regular? If no, please explain: ________________

Do you consider the applicant physically and emotionally capable of participating in intensive academic work plus part-time employment should that be necessary? ❑ Yes ❑ No

Name of Physician____
PLEASE PRINT SIGNATURE

Address:____

Phone Number (_____) ________ - ______________ Date of Examination ________________