



For College Procedure 7.01.03.10: *Immunization
Tuberculosis Testing and Physical Examination
Requirements for Health Career and Nursing Students*

REPORT OF HEALTH EVALUATION

For Students in Health Occupations Programs

LAST NAME (PLEASE PRINT)		FIRST NAME		MIDDLE	PROGRAM		DATE OF ENTRY		
HOME ADDRESS (Number and Street)			CITY		STATE	ZIP CODE		DOB	
NAME, RELATIONSHIP, ADDRESS & PHONE # OF EMERGENCY CONTACT					PATIENT'S HOME NUMBER: _____ CELL NUMBER: _____ EMAIL: _____				
FAMILY HISTORY		Diabetes:		Heart Attack:		High Cholesterol:		High Blood Pressure:	
		Cancer:		Stroke:		Mental Health Dz:		Other:	
Who do you live with:					Pets:				
					Indoor or outdoor				
PERSONAL HISTORY:					Please answer all questions. Comment on all positive answers below.				
Have you had:					Have you had:				
INFECTIOUS DISEASES					ENDOCRINE/METABOLIC				
Measles		Y	N			Diabetes		Y	N
German Measles		Y	N			Thyroid Problems		Y	N
Mumps		Y	N			Other (Describe)		Y	N
Chicken Pox (at what age)		Y	N			MUSCULO-SKELETAL			
Malaria		Y	N			Disease or Injury of Joints		Y	N
Tuberculosis		Y	N			Arthritis		Y	N
Mononucleosis		Y	N			"Trick Knee"/Shoulder, etc.		Y	N
Hepatitis		Y	N			Back Problems		Y	N
Sexually Transmitted Disease		Y	N			Other (Describe)		Y	N
Other (Describe)		Y	N			FEMALES ONLY			
EYES/EARS/MOUTH					First day of last menstrual period				
Gum or Dental Problems		Y	N			Irregular Periods/Excess		Y	N
Sinusitis		Y	N			Severe Cramps		Y	N
Eye Problems		Y	N			Current Pregnancy		Y	N
Ear Problems		Y	N			Other (Describe) G, P, A, L		Y	N
Throat Problems		Y	N			CARDIO-PULMONARY			
IMMUNOLOGICAL					Shortness of Breath		Y	N	
Hay Fever (Seasonal allergies)		Y	N			Palpitations		Y	N
Asthma		Y	N			Chest Pains/Pressure		Y	N
Allergies To: Medicines		Y	N			Chronic Cough		Y	N
Foods		Y	N			High Blood Pressure		Y	N
GI AND GU DISORDERS					Rheumatic Fever		Y	N	
Frequent Nausea		Y	N			Heart Murmur		Y	N
Frequent Diarrhea		Y	N			Recurrent Colds		Y	N
Constipation		Y	N			Other (Describe)		Y	N
Frequency of Urination		Y	N			MISCELLANEOUS			
Burning on Urination		Y	N			Tumors		Y	N
Gall Bladder Problems		Y	N			Cancer		Y	N
Other (Describe)		Y	N			Cysts		Y	N
NEUROLOGICAL DISEASES					Other (Describe)		Y	N	
Frequent Headaches		Y	N			PSYCHOLOGICAL			
Dizziness or Vertigo		Y	N			Mental Health Disorder(s)		Y	N
Head Injury/Unconsciousness		Y	N			Insomnia		Y	N
Epilepsy/Convulsions		Y	N			Frequent Depression/Anxiety		Y	N
Fainting		Y	N			Alcohol (ETOH)		Y	N
Weakness		Y	N			Smoking		Y	N
Paralysis		Y	N			Recreational Drugs (cocaine/marijuana)			
Other		Y	N			Miscellaneous			
BLOOD DISORDERS					Surgery		Y	N	
Clotting Disorder		Y	N			Hospitalizations overnight		Y	N
Hemophilia		Y	N			Major Accidents		Y	N
Leukemia		Y	N			Other (Describe)		Y	N
Anemia (Type)		Y	N			CURRENT MEDICATIONS (List)		Y	N

Reviewed by: _____ Date: _____

- A. Has your physical activity been restricted during the past five years? **YES** _____ **NO** _____ (Give reasons) _____
- B. Have you had difficulty with school studies or teachers? **YES** _____ **NO** _____ (Describe) _____
- C. Have you received treatment or counseling for a nervous condition, personality or character disorder, emotional problems or chemical/alcohol dependence? **YES** _____ **NO** _____ (Give details) _____
- D. Have you had any illness or injury or been hospitalized other than that already noted? **YES** _____ **NO** _____ (Give details) _____
- E. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years? (Other than routine checkups?) **YES** _____ **NO** _____ (Give Details) _____
- F. Have you been rejected or discharged from military service or employment because of physical, emotional, or other reasons? **YES** _____ **NO** _____ (If so, give reasons) _____
- G. Do you have any learning disabilities for which you may require assistance? **YES** _____ **NO** _____ (Describe) _____

I certify this personal history information to be correct: _____

Student (CLIENT) Signature

Date

TO THE EXAMINING PHYSICIAN/ADVANCED PRACTICE NURSE/PHYSICIAN ASSISTANT: Please review the student's history and complete the physical form. Please comment on positive answers. This information is for the use of the Health Careers Programs and will not be released without student consent. *Physician/Advanced Practice Nurse/Physician Assistant must be licensed in the United States.*

LAST NAME (Please Print) _____ **FIRST NAME** _____ **MIDDLE NAME** _____ **GENDER** _____ **AGE** _____

Height _____ Temp _____ B/P _____ **Corrected/Non-Corrected Vision:** R _____ L _____ Both _____

Weight: _____ Pulse _____ Resp. _____ O2 Sat on RA _____ % Corrective Lenses: **Y/N** Why _____ How Long _____

IMMUNIZATIONS REQUIRED BY EPCC: DATES (Immunization Record/Copy must be attached)

Varicella: 1st _____ 2nd _____ **OR** Age of actual Illness _____ **OR BLOOD TITER** _____

Polio (3 doses up to age 19) _____

Measles, Mumps, Rubella: 1st _____ 2nd _____ **OR BLOOD TITER** _____

Tdap (Tetanus, diphtheria, pertussis) or Td (dose in past 10 years) _____

Tuberculin Skin Test (Chest X-ray, if indicated) _____ **NEGATIVE** _____ **POSITIVE** _____

Hepatitis B: 1st _____ 2nd _____ 3rd _____ **OR BLOOD TITER** _____

Other: _____

Physical Assessment	Normal	Abnormal	Not Examine	Comments
1. Head, Ears, Nose, or Throat				
2. Respiratory				
3. Cardiovascular/Blood				
4. Gastrointestinal				
5. Hernia				
6. Eyes				
7. Genitourinary (Males only)				
8. Musculoskeletal				
9. Metabolic/Endocrine				
10. Neurological				
11. Skin				
12. Psychiatric/Emotional				

Recommendations for physical activity (including lifting, carrying, or standing) **Unlimited/ Limited** _____

Recommendations for accommodations for any learning disabilities, physical disabilities, or emotional disabilities **Yes/No**

(Explain) _____

General Comments: _____

EXAMINER'S SIGNATURE

EXAMINER'S NAME and TITLE (typed or printed)

ADDRESS

PHONE

FAX

DATE