REPORT OF HEALTH EVALUATION

For Students in Health Occupations Programs

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

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: Cancer:	Heart Attack: Stroke:	High Cholesterol: Mental Health Dz:	High Blood Pressure: 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: _____

The EPCCCD does not discriminate on the basis of race, color, national origin, religion, gender, age, disability, veteran status, sexual orientation, or gender identity.

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 Examined	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**