

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		Yes	No	Relationship
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____				

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

	Yes	No	Age		Yes	No	Age	
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	_____	Impaired Sight	<input type="checkbox"/>	<input type="checkbox"/>	_____	List any Allergies: _____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emotional Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Measles	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Use of Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	_____	Use of Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____	List any other Major Illnesses: _____
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Use of Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	_____	Regular use of				_____
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Regular use of				_____
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diet Pills	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	_____					List any surgeries you have undergone in
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	List any Major Injuries: _____				the last 5 years: _____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____				_____
Draining Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____				_____
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____				_____
Typhoid Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____				_____

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	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Abdomen	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Thyroid	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Extremities	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Scalp	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Skin	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Eyes	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Neurological	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Ears	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Muscular System	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Nose and Sinuses	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Endocrine	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Mouth, Teeth, Throat	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Genitalia	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Chest and Lungs	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Breast Exam	<input type="checkbox"/> Normal	<input type="checkbox"/> 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 _____