

PERSONAL HISTORY To be completed by student or guardian

EYE			URINARY PROBLEMS		
Corrective Lenses or Contacts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Stones	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Urinary Tract Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Remarks: _____			Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ENT			Remarks: _____		
Ear Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	MUSCULOSKELETAL	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nose	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Back Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Disease or Injury of Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Remarks: _____			Remarks: _____		
HEART DISEASE			HEMATOLOGICAL/ONCOLOGICAL	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Remarks: _____		
Palpitations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	NEUROLOGICAL/PSYCHOLOGICAL	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Remarks: _____		
Remarks: _____			GYNECOLOGICAL PROBLEMS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
RESPIRATORY SYSTEMS			Remarks: _____		
Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	ABDOMINAL PROBLEMS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Remarks: _____		
Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Remarks: _____					

Please comment on all positive answers in the space provided (or on an additional sheet).

Have you ever been treated for:

Frequent or severe headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Remarks: _____
Seizure or seizure disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Remarks: _____
Skin disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Remarks: _____
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Remarks: _____
Frequent respiratory infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Remarks: _____
Stomach/intestinal problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Remarks: _____
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Remarks: _____
Infectious Mononucleosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Remarks: _____
Anemia or blood disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Remarks: _____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Remarks: _____
Anxiety or depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Remarks: _____

Are you taking any herbal, vitamin, or dietary supplements on a regular basis? (list) _____

Medications: _____

FAMILY HISTORY

	Age	State of Health	Occupation	Age of Death	Cause of Death
Father					
Mother					

Number of Brothers: _____ Number of Sisters: _____

Have either of your parents ever had: (check all that apply)

- Tuberculosis Kidney disease Diabetes
 Cancer (what types?) _____ Heart disease/High blood pressure Other

PHYSICAL EXAMINATION To be completed by physician

Height: _____ Weight: _____ BP: _____ Pulse: _____
 Medications: _____
 Eyes WNL Remarks: _____
 ENT WNL Remarks: _____
 Neck WNL Remarks: _____
 Lungs WNL Remarks: _____
 Heart WNL Remarks: _____
 Abdomen WNL Remarks: _____
 Psychiatric WNL Remarks: _____
 G.U. WNL Remarks: _____
 Skin WNL Remarks: _____
 Neuro WNL Remarks: _____
 Musculoskeletal WNL Remarks: _____
 Additional Remarks: _____

IMMUNIZATION

Polio Completed primary series of Polio immunizations Date of last booster: _____
 Diphtheria Completed primary series of Diphtheria Date of last booster: _____
 Tetanus Completed primary series of Tetanus Date of last booster: _____
 MMR Two immunizations after 12 months of age
 Date of dose 1: _____ Date of dose 2: _____ or Titer: _____
 Mantoux Test Date: _____ required within 1 year reactive non-reactive (if reactive, chest x-ray required.)
 Hepatitis B Vaccine Date 1: _____ Date 2: _____ Date 3: _____
 Meningococcal Vaccine Date: _____ 1 dose covers 3-5 years
 Varicella Vaccinated Date 1: _____ Date 2: _____ OR was diagnosed with disease Date: _____
 Other _____

Is there a history of any psychological concerns that may affect the students performance in class and/or living situation? If so, how may the university help? _____

Is this student medically qualified to participate in our vigorous dance and musical theater programs? Yes No N/A

After considering the history and physical examination, in your professional opinion, is this student able to meet the physical and emotional demands of college? _____

Physician's Signature: _____	Telephone Number: _____
Address _____	
Print Last Name: _____	
Date Examination was completed: _____	Fax Number: _____
PHYSICIAN'S STAMP:	

