SCHOOL OF HEALTH PROFESSIONS

Clinical Affiliation
Physical Examination

Student: Please complete this page before going to your physician for examination.

STUDENT NAME	STUDENT EMPLID	DATE OF BIRTH	SEX	E-MAIL	MAJOR

HOME ADDRESS (Number & Street)	CITY or TOWN	STATE/COUNTRY	ZIP

HOME NO.	CELL NO.	EMERGENCY CONTACT	PHONE NO.

To be completed by STUDENT: **PERSONAL HISTORY**

HAVE YOU HAD:	Yes	No		Yes	No
Scarlet Fever			Insomnia		
Measles			Frequent Anxiety		
German Measles			Frequent Depression		
Mumps			Worry or Nervousness		
Chicken Pox			Recurrent Headaches		
Malaria			Recent Colds		
☐ Gum ☐ Tooth Trouble			Head injury with Unconsciousness		
Sinusitis			☐ Hay Fever ☐ Asthma		
Eye Trouble			Tuberculosis		
☐ Ear ☐ Nose			Shortness of Breath		
☐ Throat Trouble					
			Allergy		
Surgery			Penicillin		
Appendectomy			Sulfonamides		
Tonsillectomy			Serum		
Hernia Repair			Foods (which)		
Other			Other		
Chest			Gallbladder Trouble		
☐ Pain ☐ Pressure			or Gallstones		
Chronic Cough			Recurrent Diarrhea		
Palpitations (Heart)			☐ Rupture ☐ Hernia		
High Blood Pressure			Recent Weight		
Low Blood Pressure			☐ Gain ☐ Loss		
Rheumatic Fever			☐ Dizziness ☐ Fainting		
Heart Murmur			☐ Weakness ☐ Paralysis		
Joint Problems:			☐ Epilepsy ☐ Convulsions		
Trick Knee					
Shoulder			Smoker – How many per day		
Back Problems					
☐ Tumor ☐ Cancer ☐ Cyst			**FEMALES ONLY**		
Jaundice			Irregular Periods		
Stomach Trouble			Severe Cramps		
Intestinal Trouble			Excessive Flow		
☐ Diabetes ☐ Hypoglycemia					

STUDENT AFFIDAVIT: I hereby certify that all information entered is complete and accurate.

Student Signature _____ **Date** _____

To be completed by PHYSICIAN:

IMMUNIZATIONS AND TESTS – Please give complete dates (Month/Day/Year)

	Dates of Immunization	*Date of Disease*	*Titer Result & Date (P)ositive or (N)egative*
Varicella	1st 2nd		
Rubeola	1st 2nd		
HBV (Highly recommended; *required for PA students*) *	1st 2nd 3rd		
Tetanus Toxoid (Recommended)			NA

* If you choose not to have the HBP, you must sign the attached declination form

I HAVE EXAMINED THE FOLLOWING:

	FINDINGS:
1. Head, Ears, Nose, & Throat	
2. Respiratory	
3. Cardiovascular	
4. Gastrointestinal	
5. Hernia(s)	
6. Eyes	
7. Genitourinary	
8. Musculoskeletal	
9. Metabolic/Endocrine	
10. Neuropsychiatric	
11. Skin	

TST I.D. (Mantoux) **Mandatory**
Date Administered: _____
Date Read: _____ Results: _____mm
TST Read by: _____

(If TST/Mantoux is positive, chest x-ray is required and report must be attached)

Height _____ Weight _____
Blood Pressure _____
Vision: R _____ L _____ Corrected: R _____ L _____
Hemoglobin (if indicated): _____gms%

Please check one of the following:

_____ May participate in clinical experience in health care agencies or organizations.

_____ Must be restricted or adaptive program designed for her/his physical limitations. Indicate specific limits.
_____

_____ Should not participate in clinical experiences.

Physician's Signature _____ Physician's License # _____ **STAMP REQUIRED:**

Print Name _____

Address & Office Stamp _____