MEHARRY MEDICAL COLLEGE

Student Health Services

HEALTH SURVEILLANCE / PHYSICAL EXAMINATION

1. STUDENT'S INFORMATION

Name: _____ SSN: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: _____ Home Phone: _____

School: _____ Cell Phone Number: _____

2. HEALTH HISTORY (STUDENT TO COMPLETE THIS SECTION)

YES	NO		YES	NO		YES	NO	
		Any illness or injury in the last 5 years?			High blood pressure			Loss of, or altered consciousness
		Head/Brain injuries, disorders or illnesses			Muscular disease			Fainting dizziness
		Seizures/epilepsy Medication_____			Shortness of breath			Sleep disorders, pauses in breathing while asleep, daytime sleeping, loud snoring
		Eye disorders or impaired vision (except corrective lenses)			Lung disease, emphysema, asthma, chronic bronchitis			Stroke or paralysis
		Ear disorders, loss of hearing or balance			Kidney disease, dialysis			Missing or impaired hand, arm, foot, legs, finger, toe
		Heart disease or heart attach; other cardiovascular condition Medication_____			Liver disease Digestive problems			Spinal injury or disease Chronic low back pain
		Heart surgery (valve replacement/bypass, angioplasty, pacemaker)			Regular, frequent alcohol use			Narcotic or habit forming drug use
		Nervous or psychiatric disorders, e.g., severe depression Medication_____			Diabetes or elevated blood sugar controlled by: Diet Pills Insulin Medication_____			

For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.

Student's Signature _____ Date _____

Pages 2, 3 and 4 to be completed by the Health Care Provider **Name:** _____

3. VISION

Numerical readings must be provided.

ACUITY	UNCORRECTED	CORRECTED	HORIZONTAL FIELD OF VISION
Right Eye	20/	20/	Right Eye:
Left Eye	20/	20/	Left Eye:
Both Eyes			

Color Vision Normal Abnormal

Applicant meets visual acuity requirement only when wearing: Corrective Lenses

4. HEARING

A) Whisper Test Right Ear: /Feet Left Ear: /Feet

B) Audiometer Test See attached reading

5. BLOOD PRESSURE/PULSE RATE

Blood Pressure: _____

Systolic: _____

Diastolic: _____

Pulse Rate: Regular Irregular

Record Pulse Rate: _____

6. LABORATORY AND OTHER TEST FINDINGS

URINE SPECIMEN	SP.GR.	PROTEIN	BLOOD	SUGAR

7. PHYSICAL EXAMINATION

Height: _____ (in.) Weight: _____ (lbs.) BMI: _____

BODY SYSTEM	CHECK FOR:	YES	NO
1. General Appearance	Marked overweight, tremor, signs of alcoholism, problem drinking or drug abuse		
2. Eyes	Pupils unequal, no reaction to light, impaired accommodation, impaired ocular motility, ocular muscle weakness, abnormal extraocular movements, nystagmus, exopthalmus. Ask about retinopathy, cataracts, aphakia, glaucoma, macular degeneration		
3. Ears	Scarring of tympanic membrane, occlusion of external canal, perforated eardrums		
4. Mouth and Throat	Irremediable deformities likely to interfere with breathing or swallowing		
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker implantable defibrillator		

Pages 2, 3 and 4 to be completed by the Health Care Provider **Name:** _____

BODY SYSTEM	CHECK FOR:	YES	NO
6. Lungs and chest, not including breast examination	Abdominal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rales, impaired respiratory function, cyanosis. Abnormal findings on physical exam may require further testing such as pulmonary tests and/or x-ray of chest.		
7. Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness		
8. Vascular System	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins		
9. Genito-urinary	Hernias		
10. Extremities	Loss of impairment of leg, foot, toe, arm, hand, finger, perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp and prehension in upper limb to maintain grip. Insufficient mobility and strength in lower limbs.		
11. Spine, other musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness.		
12. Neurological	Impaired equilibrium, coordination of speech pattern; asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal Patellar and Babinki's reflexes, ataxia		

COMMENTS:

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_____ _____

Health Care Provider's Signature Date

Pages 2, 3 and 4 to be completed by the Health Care Provider **Name:** _____

8. IMMUNIZATION RECORD	
MMR VACCINE	Date of Immunization #1 #2
MUMPS	Date and Result of Titer
RUBEOLA	Date and Result of Titer
RUBELLA	Date and Result of Titer
VARICELLA	Date of Immunization
VARICELLA	Date and Result of Titer
HEPATITIS B	Dates of Immunization #1 _____ #2 _____ #3 _____ Date and Result of Titer
Td or TdAP	Date
POLIO	Date of Last Immunization
PPD	Date and Result
Chest X-Ray (If Required)	Date and Result

1. Does the student have any medical or psychiatric diagnoses that may interfere with their matriculation in professional/graduate school?

   No Yes If yes, please explain: _____

2. Are you the student's primary care provider?	No	Yes

Health Care Provider's Signature & Date: _____

Printed Name: _____

Address: _____

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