



PHYSICAL EXAMINATION REPORT

Student's First Name	Middle Initial	Family Name	Date of Birth (Month/Day/Year)		
Address		City	State	Postal Code	Country

Medical History (Check Each Item)

Have you had or do you have?

	Yes	No		Yes	No		Yes	No
Measles			Eating Disorder			Epilepsy/Seizure Disorder		
Mumps			Sexually Transmitted Disease			Diabetes		
Rubella			Strokes			Rheumatic Fever/Heart Disease		
Chicken Pox			Tuberculosis			Hernia		
Asthma			Broken Bones			Malaria		
Appendicitis Chronic			Cancer			Concussion or Head Injuries		
Enuresis			Vertigo/Dizziness					
Thyroid (Goiter, Struma)			Hepatitis					
Parasites			Hernia					
			Sleepwalking					

Have you ever been hospitalized, had surgery, or been under extended medical care? If yes, for what reason?

List medications taken regularly: _____

Systemic Review

Do you have any of the following? (Check Each Item)

Ears, Eyes, Nose, Throat	Yes	No		Yes	No		Yes	No
Eye Disease or Injury			Glaucoma			Hearing Problems		
Do You Wear Glasses			Nosebleeds			Do You Wear Hearing Aids		
Double Vision			Chronic Sinus Trouble			Dizziness		
Headaches			Ear Disease			Episodes of Unconsciousness		
Skin			Neck			Respiratory		
Skin Disease, Hives, Eczema			Stiffness			Spitting Up Blood		
Jaundice			Thyroid Trouble			Chronic Cough		
Frequent Infection or Boils			Enlarged Glands					
Abnormal Pigmentation								

If "yes" was checked for any of the above, a physician must provide full details (use additional sheet if needed):

Allergies and Sensitivities (Check Each Item)

Is there a history of skin reaction or other reaction or sickness following injections or oral administration of:

	Yes	No		Yes	No
Penicillin or other antibiotics			Tetanus, Antitoxin or Other Serums		
Morphine, Codeine, Demerol or Other Narcotics			Any Foods (i.e. Eggs, Milk, Chocolate)		
Aspirin, Empirin or Other Pain Remedies			Pets/Animals		
			Other: _____		

If "yes" was checked for any of the above, please list or explain (Use additional sheet if needed) _____

Neuro-Psychiatric

Have you ever had challenges with stress, anxiety, or depression in the past?
 If yes, have you sought help for this issue in the form of therapy or counseling?
 When under stress or feeling anxious, what has helped you to cope? _____

Yes No

