

**HEALTH HISTORY/PHYSICAL EXAMINATION FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| FIRST NAME | | | LAST NAME | | |
| DOB | GENDER | | PHONE | | |
| ADDRESS | | CITY | | STATE | ZIP |

**TO BE FILLED OUT BY THE HEALTH CARE PROVIDER**

|  |  |  |  |
| --- | --- | --- | --- |
| Height | Weight | Pulse | Blood Pressure |
| **EXAMINATION** | **NORMAL** | **ABNORMAL** | **COMMENTS** |
| Head, Neck, and Thyroid |  |  |  |
| Nose and Sinuses |  |  |  |
| Mouth, Throat, Teeth, and Gums |  |  |  |
| Eyes |  |  |  |
| Ears |  |  |  |
| Skin |  |  |  |
| Chest and Lungs |  |  |  |
| Heart and Vascular System |  |  |  |
| Gastrointestinal System and Abdomen |  |  |  |
| Musculoskeletal System and Extremities |  |  |  |
| Neurological |  |  |  |
| Mental Health |  |  |  |
| OTHER |  |  |  |
| MEDICATIONS CURRENTLY TAKING: | | | |
| PAST MEDICAL HISTORY: | | | |
| PAST SURGICAL HISTORY: | | | |

I have given the student a complete physical examination. I feel that he/she is physically and mentally capable of participating without hazard, in clinical practice settings for Metropolitan Community College’s Health Professions program.

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Health care provider’s name and title (PLEASE PRINT) Health care center/facility

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health care provider’s signature Address, city, state, zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State licensure number Phone

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Date