PHYSICAL EXAMINATION

MEDICAL HISTORY

Page 1 - To be completed by Applicant

This form is confidential and will not be released without a signed statement from the student.

Name ____

MEDICAL HISTORY

History of Disease (please check and give approximate age)

( ) Rheumatic Fever ____
( ) Measles ____
( ) German Measles ____
( ) Mumps ____
( ) Chickenpox ____
( ) Whooping Cough ____
( ) Smallpox ____
( ) Asthma ____
( ) Diabetes ____
( ) Sinusitis ____
( ) Bronchitis ____
( ) Pneumonia ____

( ) Tuberculosis ____
( ) Diphtheria ____
( ) Poliomyelitis ____
( ) Scarlet Fever ____
( ) Typhoid ____
( ) Malaria ____
( ) Mononucleosis ____
( ) Epilepsy ____
( ) Hepatitis ____
( ) Gastric Ulcer ____
( ) Arthritis ____
( ) Tonsillitis ____

PERSONAL HISTORY

Are you able to perform the duties required in the clinical areas?

List of medications currently taking:

List of any known drug allergies:

Date of Diptheria/Tetanus Toxoid Vaccination	**Dates of MMR (Measles, Mumps, Rubella) Vaccination and/or Titer (If birthdate before 1957, not required.)**	**Date of Varicella (Chickenpox) Titer or Positive History**	**Dates of Hepatitis B Vaccination Series Completion or Refusal of Vaccine**	**Date of TB Test (PPD) or chest x-ray (within 12 months)**

I certify that this information is true and correct to the best of my knowledge. I further understand that falsification of information on this form is justification for non-acceptance or termination from the Health Occupations Program.

____ ______________________
Signature of Applicant Date

Receipt of this completed medical history is required by the clinical sites for students to be eligible to practice in the clinical facilities.

PHYSICAL EXAMINATION
Page 2 - To be completed by Physician

NAME ____ DATE ____________________
(last) (first) (middle)

Height	Weight	Color Hair	Color Eyes
Blood Pressure	Pulse	Vision	Hearing

CLINICAL EVALUATION			**Notes** - Describe every abnormality in detail. (use additional sheets if necessary)
Normal	**Abnormal**	(Check each item in appropriate column) (N.E. if not evaluated)	
		1. Head	
		2. Ears (general)	
		3. Eye (general)	
		4. Nose	
		5. Oropharynx	
		6. Neck	
		7. Lungs	
		8. Heart	
		9. Breast	
		10. Abdomen	
		11. Genitalia	
		12. Musculoskeletal	
		13. Neurological	
		14. Psychiatric	

LABORATORY FINDINGS (if indicated)				
Urinalysis	Albumin	Sugar	Microscopic	Hematocrit or Hemoglobin (women)

Allergies - Food, Drug and Environmental: ____

____

Recommendation for treatment: ____

____

This person is physically capable of performing the physical skills required for
(circle one) certified massage therapy / nursing / paramedic / radiological technology. ☐ Yes ☐ No

PHYSICIAN SIGNATURE: ______________________________

(NAME PRINTED): ______________________________

Office Address: ______________________________

RETURN TO: MERIDIAN TECHNOLOGY CENTER, 1312 SOUTH SANGRE ROAD, STILLWATER, OK 74074