Student Health Record and Physical Examination

Office of Admissions
P.O. Box 1751
Dayton, OH 45401-1751

This information is strictly for use of Health Service and will not be released to anyone unless it is necessary to provide emergency health care services.

Type or print in ink

Name _____
Last First Middle
Permanent address _____
Street City State Zip
Phone _____ (home) _____(work)

E-mail _____

Social Security number _____-____-_____ Date of birth _____

Emergency contact _____
Address _____
Street City State Zip
Phone _____ (home) _____(work)
Medical doctor _____ Phone _____
Insurance company _____
Group name _____ Group number _____
Name of insured _____
Social Security number Relationship

Personal History

Please check if you have had any of the following. Give date of illness, operation, or injury, or onset of problem, and date of last treatment.

Alcohol abuse _____
Anemia_____
Appendicitis_____
Asthma_____
Blood clots_____
Bronchitis_____
Cancer_____
Chickenpox_____
Chronic cough_____
Convulsions_____
Diabetes_____
Diphtheria_____
Drug abuse_____
Depression_____

Ear trouble _____
Eating disorder_____
Encephalitis_____
Eye trouble_____
Fainting_____
Gall bladder trouble_____
Heart problem_____
Hepatitis_____
High blood pressure_____
Hypoglycemia_____
Kidney disease_____
Malaria_____
Measles_____

Meningitis_____
Menstrual problems_____
Mumps_____
Nervous condition or mental condition____
Pneumonia_____
Recurrent headaches_____
Rheumatic fever_____
Rubella_____
Scarlet fever_____
Sexually transmitted disease_____
Sinus trouble_____
Stomach/intestinal problems_____
Tuberculosis_____
Ulcers_____

Do you have any physical limitations? _____ yes _____ no Please list_____
Do you require any assistive devices? _____ yes _____ no Please list_____
Smoking _____ yes _____ no Drinking _____ none _____ under 5 drinks per week _____ 5 or more per week.
Do you take allergy injections? _____ List allergies_____

Family History

Have any of your relatives ever had any of the following?

	Age	State of Health	Age of Death	Cause of Death			Yes	Relationship	Explain
Father						Tuberculosis			
Mother						Diabetes			
Brothers						High blood pressure			
						Heart disease			
Sisters						Arthritis			
						Hay fever			
						Asthma			
						Cancer			

Foreign Travel Vaccines

Immunization	Date

Other

Tuberculin Skin Test

☐ PPD ☐ Punct.

Date	Results

Physical Examination

Height _____ Weight_____ Age _____

B.P. _____/_____ Temp _____ Pulse _____ Resp. _____

Hearing: Rt. _____ Vision: Rt. _____ corrected to _____

Lt. _____ Lt. _____ corrected to _____

Lab: U/A—Glucose _____ Protein _____ Micro _____ Hb/Hct.—_____/_____

Check Each Item	Normal	Abnormal	Please Give Details of Each Abnormality
1. Head, neck scalp			
2. Nose, sinuses			
3. Mouth, teeth, gums, throat			
4. Ears			
5. Eyes			
6. Chest, lungs			
7. Breasts			
8. Cardiovascular			
9. Abdomen			
10. Hernia			
11. Lymphatics			
12. Genital and pelvic			
13. Ano-rectal			
14. Spine			
15. Hands, upper extremities			
16. Feet, lower extremitates			
17. Skin, nails			
18. Neurological exam			
19. Mental status			

Signature _____ Date_____
Healthcare Provider and Credentials