IOWA WESTERN

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Medical History and Physical Examination

This page to be completed by the student:

Name:______________________________ Male:_______ Female:_______

Home Address:______________________________
Street City State Zip

Date of Birth:______________________ Phone Number: ______________________

Parent/Legal Guardian:______________________ ______________________
Name Relationship

Parent/Legal Guardian Address:______________________________

Phone:______________________(Home) ______________________(Work)

Family Physician:______________________________
Name Address

Health Insurance: Yes____ No____ (If yes attach copy of insurance card)

Personal Health Information

Have you ever had or have now?								
Yes	**No**	*Check each item on left*	**Yes**	**No**	*Check each item on left*	**Yes**	**No**	*Check each item on left*
		Arthritis			Headaches/migraines			Rheumatic fever
		Anemia			Hearing loss			Seasonal Allergies
		Asthma			Heart trouble			Stroke
		Cancer			Hepatitis			Substance abuse
		Convulsion/seizure			High blood pressure			Thyroid disorder
		Depression/psychological disorder			Kidney/bladder problems			Tuberculosis
		Diabetes			Menstrual problems			Ulcer
		Eating disorder			Multiple Sclerosis			Other:

Yes	**No**	
		Have you been exposed to or had any communicable diseases? If, so specify diseases, or exposure, i.e., hepatitis, TB.
		Allergy to drugs, plants, latex, etc. (list all allergies)
		Injuries (specify body location & date)
		Operations (specify & date)
		Have you visited a foreign country in the last 5 years? If so, what country?
		Have you arrived in the U.S. from a foreign country in the last 5 years? If yes, what country?
		Do you have any specialist physicians? If yes, who and for what?
		Other illness or complaints (specify)

Are you currently taking any prescription, over-the-counter, herbs or other types of medication? ________ If Yes, please specify:______________________

____

All information on this physical is complete and accurate; I understand that failure to report all information accurately may result in denial of entry or dismissal from program as appropriate to the circumstances.

Signature:______________________________ Date:______________________

History/Updating of Immunizations

Student's Name:

Hepatitis B Titer – *MANDATORY*	MMR Antibody Titer - *MANDATORY*	Optional Immunizations
Antibody (AB) Date ___________ Results ___________ *Documentation of lab titer result is MANDATORY*	Rubeola Titer Date _________ Results ___________ Mumps Titer Date _________ Results ___________ Rubella Titer Date _________ Results ___________ *Documentation of lab titer result is MANDATORY*	MENINGITIS: Date SMALL POX: Date
Varicella Antibody Titer (Chicken Pox) – *MANDATORY* Date _____________ Results ___________ *Documentation of lab titer result is MANDATORY. Date of injections or childhood illness dates* ***DO NOT APPLY.***	Influenza: Seasonal influenza is required prior to clinical experience Date _______________ Lot # _______________ Sticker: Expiration Date ___________	***Nursing & Surgical Tech Students*** • Mandatory Drug Screen – to be scheduled at/after orientation • **Negative Results of a titer conversion require repeated immunization OR a physician's note stating that the individual is a non-converter. The letter of Non-conversion must be on an official letter head, not an rx pad, and signed by an MD or DO Or Nurse Practitioner.**
Tuberculin (ppd) OR Chest X-ray and physician's note: **Initial 2-Step:** Date Given:_________ Date Read:_________ Results:_________ Date Given:_________ Date Read:_________ Results:_________	TDAP: Valid only if within 10 years — Date: — Updated: ***TB (ppd) OR* Chest x-ray report** ****if student had previous positive TB result **** — Date: Results:	

Height: ___________ Weight: ________________ Color Vision: ___________

Distant Vision: Right 20/ Corr. To 20/

Left 20/ Corr. To 20/

Temp.: __________ Pulse: __________ Resp. ______________ Blood Pressure __________________

CLINICAL EVALUATION:

Normal	Abnormal	Check each item in appropriate column.
		1. H E E N T
		2. LUNGS and CHEST (include Breasts)
		3. HEART
		4. ABDOMEN/hernia
		5. G-U SYSTEM
		6. MUSCULOSKELETAL SYSTEM
		7. SKIN, LYMPHATIC GLANDS
		8. NEUROLOGIC SYSTEM
		9. To your knowledge, does this individual have a history of substance/drug abuse?
		10. Are there any physical restrictions including lifting and/or sports-related concerns? If yes: please describe: ____

YES	NO	N/A	
			A. Do you recommend this person for entry into a health care field with its high level of stress and responsibility?
			B. Do you consider this person capable of making health care judgments?
			C. Do you consider this person to be capable of caring for young children in a professional setting?

NOTES: Describe any abnormality:

Include any recommendations (for treatment, restriction of academic load, lifting, sports, etc.)

Examining Physician: ____ Address: ____

Signature & Date: ____ Phone Number: ____

Print Name: ____ Office Fax Number: ____

DO NOT FAX THIS DOCUMENT TO THE SCHOOL, ALL DOCUMENTATION TO BE UPLOADED INTO CASTLE BRANCH BY THE STUDENT.

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