

Health & Physical Exam Form



UNIVERSITY of SAINT FRANCIS

Health Science Students and Collegiate Athletes
 must have a medical record proof of immunization and physical exam on file with the University. Please fill in Part I; then take the form to your healthcare provider for an exam and completion of the form.

2701 Spring Street
 Fort Wayne, IN 46808
 260-399-7700
 www.sf.edu

PART I:

Name _____ Home phone () _____
 Last First Middle

Address _____ Date of Birth _____
 Street City State Zip

Female Male Single Married

Medical Insurance Company _____ Policy Number _____

Address _____ Phone Number _____
 Street City State Zip

In case of any emergency, please contact

Name _____ Relationship _____ Home No. _____ Work No. _____

History

| | Yes | No | Date | | Yes | No | Date |
|--------------------------------|-----|----|------|-----------------------------------|-----|----|------|
| Alcohol/drug abuse | | | | High blood pressure | | | |
| Anemia | | | | Joint dislocation | | | |
| Anorexia or Bulimia | | | | Joint or limb problems, injuries | | | |
| Anxiety/Depression | | | | Kidney Disease | | | |
| Asthma | | | | Major injury (list below) | | | |
| Back problems | | | | Menstrual problems | | | |
| Bleeding tendencies | | | | Obesity | | | |
| Bowel Disease | | | | Operations (list below) | | | |
| Cancer | | | | Osgood – Schlatter Disease | | | |
| Concussion | | | | Osteomyelitis | | | |
| Diabetes or Hypoglycemia | | | | Physical limitations (list below) | | | |
| Emotional/Psychiatric problems | | | | Seizure Disorder | | | |
| Fracture/broken bone | | | | Sickle Cell Trait | | | |
| Headaches, Migraines | | | | Sleep disorder | | | |
| Hearing Deficit | | | | TB or Lung Disease | | | |
| Heart Disease | | | | Thyroid Problems | | | |
| Heart Murmur | | | | Ulcer | | | |
| Hepatitis A, B, C (circle) | | | | Visual difficulty | | | |

Describe any health problem(s) noted above for which you are currently being treated. Attach a separate page if necessary.

List current medications being taken.

List allergies (food, drug and other)

Are you presently suffering from an infectious or communicable disease that may pose a direct threat to the health and safety of others in the academic or clinical environment? Yes or No If yes, please identify and explain your condition: _____

In the interest of protecting your own health and safety, do you presently have or do you have a history of any condition which might weaken your immune system or otherwise render you particularly susceptible if exposed to contracting an infectious or communicable disease (e.g. anemia, hemophilia, etc.)? Yes or No If yes, please identify and explain your condition: _____

Immunization Profile

| | | | | | | | | |
|--|-----------------|------|--------------------------|-----------------|------|---------------|-------|------|
| Tetanus Toxoid or Diphtheria/Tetanus** within the last 7 – 10 years: | Booster | Date | MMR (combined) or ↓: | 1 st | Date | Chicken Pox | 1st | Date |
| | Primary | | | 2nd | | | 2nd | |
| Hepatitis B Vaccine | 1 st | | Measles (Rubeola) | | | Or | Titer | |
| | 2 nd | | Mumps | | | HPV* | | |
| | 3 rd | | Rubella (German Measles) | | | Flu Vaccine * | | |
| Hepatitis B Titer | | | Polio | Primary | | Pneumonia * | | |
| | | | | Booster | | Meningitis * | | |
| | | | | Booster | | Hepatitis A* | | |

*Optional **Required every 10 years or Tdap

Infectious / Communicable Disease History - Please indicate whether or not you have had the following:

| | | | | | |
|-------------------------|--|-----------------|--|----------------|--|
| Chicken Pox | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| German Measles Rubella) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Measles (Rubeola) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis #1 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis #2 | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

I certify the above information is complete and accurate. I acknowledge that I have a continuing obligation to inform the university of any changes in my health status that are relevant to the information requested by this form.

Signature of Student _____ Date _____

PART II (to be completed by physician or healthcare provider)

Vital Signs

| | | | | | |
|--------|--------|------|-------|-------------|----------------|
| Height | Weight | Temp | Pulse | Respiration | Blood Pressure |
| | | | | | |

Clinical Evaluation

| | | | |
|---------------------------------------|--------|----------|------------------------|
| Check each item in appropriate column | Normal | Abnormal | Describe abnormalities |
| Skin | | | |
| Eyes, glasses/contact lens | | | |
| Ears | | | |
| Noses / sinuses | | | |
| Oral cavity | | | |
| Neck | | | |
| Respiratory | | | |
| Cardiovascular | | | |
| Gastrointestinal | | | |
| Musculoskeletal | | | |
| Spine | | | |
| Nervous system | | | |
| Extremities | | | |
| Physical or mental disability | | | |
| Hernia, Genitalia / Pelvic | | | |
| Other | | | |

Test for Tuberculosis within the past year

| | | | | | |
|--|---------------------|-----------|---------------------|-----------|--|
| Mantoux (PPD) ____ | Date given and site | Signature | Date read / results | Signature | Chest x-ray Date: _____ Results: _____ |
| 2 nd step Mantoux (PPD) ____ | Date given and site | Signature | Date read / results | Signature | Chest x-ray Date: _____ Results: _____ |

COLLEGIATE ATHLETE (I have examined this student and find him/her physically capable to compete in supervised athletics.)

Printed name of Physician or Healthcare Provider _____ Phone number _____

Address _____
Street City State Zip

Signature of Physician or Healthcare Provider _____ Date _____

Submit form to: **Original:** School of Health Sciences _____ Department **Copy:** Athletic Trainer