HEALTH HISTORY FORM

Personal Data

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: _____

Emergency Contact Name: _____Relationship: _____ Phone: _____

Health History:

Check below to indicate whether you have (or had in the past) any of the following:

Yes	No	Date	Condition:	Comments:
			Anemia (including sickle cell)	
			Asthma	
			Bleeding disorder	
			Blindness (complete or partial)	
			Cancer (including leukemia, Hodgkin's Disease)	
			Colitis, ulcerative	
			Diabetes	
			Epilepsy or other seizure disorder	
			Hearing loss (complete or partial)	
			Cardiac Pathology	
			High blood pressure	
			Inflammatory bowel disease	
			Migraine headache	
			Rheumatoid arthritis	
			GERD (reflux)	
			Thyroid dysfunction	
			Substance abuse (alcohol and/or drugs)	
			Emotional/psychiatric problems that limit work ability	
			Other:	
			Other:	

Name any illness or health condition for which you are CURRENTLY under treatment

_____

List any surgeries and/or hospitalizations:

Date Name/Address of Hospital Name of Physician Diagnosis

_____

_____

_____

List any medicine, food, or environmental substance to which you are ALLERGIC:

_____

List any **medications** you are now taking (include drug name and dose):

_____

_____

PHYSICAL EXAMINATION

(*to be completed by primary provider*):

NAME: _____ DOB: _____

ADDRESS: _____ TELEPHONE: _____

HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____ PULSE: _____ RESP: _____ TEMP: _____

Please indicate any abnormalities in the following and describe findings at right:

YES	NO		YES	NO	
		Skin:			Heart:
		Lymph Nodes:			Lungs:
		Eyes:			Ears:
		Vision (reads without difficulty): ☐ Eye glasses ☐ Contacts ☐ Other			Hearing (hears whisper at 5 ft.): ☐ Hearing aid ☐ Trochlear implant ☐ Other
		Nose:			Abdomen:
		Mouth/Throat:			Neurological:
		Other:			Other:

Do you recommend any limitations to physical activities? Yes No

If yes, specify in detail:

_____

_____

General Comments:

_____

_____

Initials:

☐ *Given the stated history and the examination measures observed during this session, this individual has the physical capacity to perform in a clinical environment.*

EXAMINER'S SIGNATURE: _____ DATE: _____

EXAMINER'S PRINTED NAME: _____

ADDRESS: _____

TELEPHONE: _____

STUDENT'S SIGNATURE: _____ DATE: _____