

THIS FORM NOT TO BE USED AT OCC STUDENT HEALTH CENTER
ORANGE COAST COLLEGE
School of Allied Health Professions/Emergency Medical Technology Program

MEDICAL HISTORY AND PHYSICAL EXAMINATION FORM

Directions to Student: Fill out Part I entirely before seeing the physician. Have the physician/practitioner complete Part II through Part VI at the time of your physical examination. Return ONLY page 3 to your Program Director in compliance with HIPAA.

I. PERSONAL DATA (This part must be completed by the student before seeing the physician/practitioner.)

Last Name _____ First Name _____ Birthdate _____
Address _____ City _____
Email _____ Telephone _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Last Name _____ First Name _____ Birthdate _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____

LOCAL PRIMARY PHYSICIAN/PRACTITIONER PREFERENCE

Name _____ Office Phone _____

MEDICAL HISTORY AND ILLNESSES - Indicate any of the following that apply:

- | | |
|---|---|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mental Health Problems |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Epilepsy/Convulsions |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Meningitis/Other Contagious Disease(s) |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Amputations |
| <input type="checkbox"/> Asthma/Hay Fever | <input type="checkbox"/> Athletic Injuries |
| <input type="checkbox"/> Difficulty in Breathing | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Genetic Diseases |
| <input type="checkbox"/> Stomach/Intestine Problems | <input type="checkbox"/> Other Illnesses: _____ |
| <input type="checkbox"/> Hernia | _____ |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Surgeries: _____ |
| <input type="checkbox"/> Kidney Disease | _____ |
| <input type="checkbox"/> Fainting | _____ |
| <input type="checkbox"/> Recurring Headaches | _____ |

If any items are checked above, please explain: _____

Yes No Do you have any physical impairment such as loss of hearing, vision, or paralysis?

If yes, please explain: _____

Yes No Do you have any allergies?

If yes, please explain: _____

Yes No Do you take medication regularly?

If yes, please list: _____

General Family Health: Mother _____

Father _____

Siblings _____

Grandparents _____

I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION GIVEN ABOVE IS COMPLETE AND CORRECT.

Student Signature _____ Date _____

II. PHYSICAL EXAMINATION (To be completed by the physician/practitioner.)

Date _____

Height _____ ' _____ " Weight _____ B/P _____ Pulse _____

	Normal	Abnormal	Explain:
General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	
Head	<input type="checkbox"/>	<input type="checkbox"/>	
ENT	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Neck	<input type="checkbox"/>	<input type="checkbox"/>	
Chest	<input type="checkbox"/>	<input type="checkbox"/>	
Breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	
Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>	
Reflexes	<input type="checkbox"/>	<input type="checkbox"/>	
Funduscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	

Describe abnormal findings or pertinent notes: _____

Student Name _____ Student ID# _____

III. REQUIRED VACCINATIONS and/or IMMUNITY: MMR (Measles, Mumps & Rubella) and Varicella -

- Documented proof of previous MMR vaccinations
o MMR (dates) 1st _____ 2nd _____ *Please attach copy of immunization record*

or

- Titers documenting MMR immunity
- | | | |
|---------------|---------------|------------|
| Measles Titer | Results _____ | Date _____ |
| Mumps Titer | Results _____ | Date _____ |
| Rubella Titer | Results _____ | Date _____ |

- Varicella Titer Results _____ Date _____

- Recent (other) Vaccinations - Type _____ Date _____

Please attach copy of any and all pertinent lab work results such as titers

IV. RECOMMENDED IMMUNIZATIONS

- Hepatitis B Vaccine (dates) 1st _____ 2nd _____ 3rd _____ Titer results _____ Date _____
- Tetanus Date Given _____
- Other: _____ Date Given _____

V. LABORATORY/DIAGNOSTIC TESTS

Tuberculosis PPD Location _____ Date Administered _____ Date Read _____ Results _____

CXR Date _____ Results _____ *Please attach a copy of radiologist report*

- CBC (optional) Urinalysis (optional) Other Practitioner Discretion Lab Work

Please attach copy of any and all pertinent lab work results such CBC/UA/Other

VI. MEDICAL CLEARANCE

- Yes No In my professional opinion as a qualified healthcare physician/practitioner, this student is physically and mentally able to participate in direct patient care and related activities in the Emergency Medical Technology Program, and presents no health risk to patients.

REMARKS: _____

Physician/Practitioner Name (Print): _____

Physician's Signature _____ Date _____

Address _____ City _____ State _____ Zip _____

Office Phone _____ Office Fax _____