MEDICAL HISTORY AND EXAMINATION FORM

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CENTER FOR HEALTH EVANGELISM

Student Name: _____ Age: _____ Gender: _____

1. Have you ever been diagnosed with any of the following conditions?
(Put a checkmark beside the ones that apply to you.)

Anemia	Diabetes	Psychiatric Illness	Tuberculosis
Allergies	Heart Disease	Seizure Disorder	Other
Asthma	Hypertension	Sexually Transmitted Disease	
Arthritis	Learning Disability	Stroke	
Cancer	Migraine	Thyroid Disease	

2. Please list any previous surgeries you have had. Also state the date of occurrence.

_____

_____

_____

3. Please list all the prescription and over-the-counter medications and supplements (herbal and nutritional) that you regularly take.

_____

_____

_____

4. Have you travelled to another country within the past six months? If yes, where and for how long?

_____

5. What type of diet do you follow?

☐ Omnivorous ☐ Vegatarian ☐ Vegan ☐ Other_____

6. How often do you exercise per week? _____

7. How many hours of sleep do you get each night?

☐ <4hrs ☐ 5-6hrs ☐ 7-8hrs ☐ >8hrs

8. What time do you usually go to sleep? _____

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9. Do you currently drink alcohol?
   ☐ Yes ☐ No
   Please specify what kind of alcohol _____
   Quantity? _____ How Often? _____ Last Time Used? _____

10. Do you use any of the following?
    ☐ Cigarettes ☐ E-cigarettes ☐ Tobacco ☐ Marijuana

11. Have you ever used an illegal substance?
    ☐ Yes ☐ No

12. Have you ever failed a drug test or been dependent on an illegal substance?
    ☐ Yes ☐ No

13. If you have answered yes to questions 11 or 12, please privde detailed information.
    _____

14. On a scale of 1-5 (1 = lowest, 5 = highest), how severe have you experienced the following?
    Depression _____ Anxiety _____ Stress _____

15. Have you ever engaged in self-harm activities (cutting, hitting, burning, etc.)?
    ☐ Yes ☐ No

16. Do you have suicidal thoughts?
    ☐ Yes ☐ No

17. Have you ever attempted suicide?
    ☐ Yes ☐ No

18. If you have answered "yes" to questions 14, 15, or 16, please provide detailed information.
    _____
    _____
    _____

Signature _____ Date _____

By signing here, I certify that the answers given herein are true and complete to the best of my knowledge. If I am accepted, I understand that false or misleading information given or omitted herein may result in dismissal.

STUDENT HEALTH EXAM REPORT

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To be completed by a medical provider.

Name of Student: _____ ☐Male ☐Female Date of Birth: _____

Past Medical History:

_____

_____

_____

Current Medical History

Current Medical Conditions:

_____

_____

_____

Current Medications:

_____

_____

_____

Allergies: ☐Yes ☐No

If yes, lease list below:

Medications _____ Food _____ Other _____

History of Anaphylaxis to _____EpiPen ☐Yes ☐No

Physical Examination

Height (ft): _____ Weight (lbs.): _____ BMI:_____

Blood Pressure: _____ Pulse: _____ Temperature: _____

Vision: Uncorrected RE 20/ _____ LE 20/ _____ Corrected RE 20/ _____ LE 20/ _____

(Check normal. If abnormal, please describe.)

General		Gastronintestinal	
Skin		Genitourinary	
HEENT		Extremities	
Dental/Oral		Nuero	
Respiratory		Neuro	
Cardio		Psych	

The entire examination was normal: ☐

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Tuberculosis

PPD Skin Test: Date _____Result _____

Chest x-ray: Date _____Result _____

Laboratory Results

(Please attach results.) ☐Normal ☐Abnormal

☐Complete Blood Count ☐Basic Metabolic Panel ☐RBG ☐Urinalysis

If abnormal, what recommendations or follow-up was given?

_____

_____

_____

Based on your evaluation, are there any work-related restrictions for this student? If so, please explain.

_____

_____

_____

Signature of Medical Pracitioner (MD/DO/NP/PA):

By signing below, I acknowledge the accuracy of the information documented on the Health Examination Report.

Signature _____ Date _____ Phone _____

Name (print): Address:

NPI#: