

PAST MEDICAL HISTORY: Has student been subject to any of the following:

Illness/Condition	Yes	No	Comments/Date(s)
Arthritis			
Tuberculosis			
Asthma			
Hypertension			
Heart Disease			
Epilepsy			
Diabetes			
Hernia			
Venereal Disease			
Hepatitis			
Injuries/Hospitalizations			
Allergies:			Specify:
Alcohol/Controlled Substance Use			Specify:
Tobacco Use			Specify:
Other			Specify:

	WNL	Abnormal	Comments
Head and Neck			
ENT			
Teeth and Gums			
Heart/Lungs			
Abdomen			
Spine			
Extremities			
Genitalia			
Skin			
Metabolic/Endocrine			

Current Treatment? (Please indicate medical, mental health, rehabilitative.) _____

Current Medications? (Please list prescription and non-prescription drugs and indicate any precautions necessary.)

Emotional or Physical Conditions that would interfere with student's attendance and progress in campus or clinical settings? (Specify.) _____

I certify that I have examined the student and have found him/her to be in good mental and physical condition.

 Signature of Practitioner Date

 Please Print Practitioner's Name

Address: _____
Street City State Zip

Phone: () _____