

 **Health Services**

P.O. Box 3450 1120 N. Ocoee Street Cleveland, TN 37320-3450

Phone: 423-614-8430 Fax: 423-464-4452

**REPORT OF MEDICAL HISTORY**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last Name First Name Middle Colleague ID Number

**If Living on Campus:**  **If Living Off Campus:**

P.O. Box # \_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dorm: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Room Number: \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ Sex: □ Male □ Female Marital Status: □ S □ M □ Other

In Case of Emergency Notify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian

Their Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Numbers: Home (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street Address)

 Work (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City, State and Zip Code)

PERSONAL MEDICAL HISTORY: **VERY IMPORTANT:** Please answer all questions. Comment on the back on all positive answers or have your family physician send a summary of your medical history to the Lee University Health Clinic.

ALLERGIES: (PLEASE LIST ALL AND DESCRIBE REACTION)

 DRUGS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 FOODS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 OTHERS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU HAD OR CURRENTLY HAVE: YES NO

1. Eye Trouble □ □
2. Ear, Nose, Throat Trouble □ □
3. Frequent or Severe Headaches □ □
4. Epilepsy/Convulsions □ □
5. Asthma □ □
6. Fainting/Passing Out □ □
7. Frequent or Severe Respiratory Infections □ □
8. High Blood Pressure □ □
9. Heart Murmur/Heart Problems □ □

**Patient/Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**YES NO**

1. Hepatitis or Jaundice □ □
2. Thyroid Problems □ □
3. Kidney Disease □ □
4. Bone/Joint Problems □ □
5. Stomach/Intestinal Trouble □ □
6. Anemia □ □
7. Diabetes □ □
8. Infectious Mononucleosis □ □
9. Thoughts of Self-Harm or Harm to Others □ □
10. Suicidal Thoughts or Suicide Attempts □ □
11. History of Substance Abuse □ □
12. Other: □ □

If you answered yes to questions 1 – 20, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Do you have any health problem and/or are receiving treatment (medications) that would require periodic evaluation?

Please explain:  **□YES □NO**

 B. Have you had any medical illness, injury, operation, or been hospitalized?

Please explain:  **□YES □NO**

1. Have you ever been hospitalized for a mental or psychiatric illness?

 Please explain: **□YES** **□NO**

D. Do you have any physical handicaps or disabilities that may restrict your physical activity?

 Please explain: **□YES □NO**

**Patient/Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

E. Are you taking psychotropic medications (i.e. Medications prescribed for mental health or behavioral conditions)? □ **YES** □**NO**

 If yes, please list name, dosage, and frequency of medication.

F. Do you have family members with chronic medical conditions?

Please check:

Heart Disease □ High Blood Pressure □ Diabetes

Cancer □ Blood Disorder □ Seizure Disorders

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I feel that I have answered these questions to the best of my knowledge:

**I do hereby give my permission for Lee University Health Clinic to release information from my physical to the appropriate persons.**

**Signature of Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient/Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**THIS PAGE IS FOR OFFICE USE ONLY:**

**PHYSICAL EXAMINATION**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BIRTHDATE: \_\_\_\_\_\_\_\_\_COUNTRY VISITING\_\_\_\_\_\_\_\_\_\_\_

HEIGHT: \_\_\_\_\_\_\_\_\_\_ WEIGHT: \_\_\_\_\_\_\_\_\_\_ PULSE: \_\_\_\_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_\_\_\_\_\_

BMI: \_\_\_\_\_\_\_\_\_\_\_\_ HEMOGLOBIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

VISION: Without/With Glasses: Right: \_\_\_\_\_\_\_\_\_\_ Left: \_\_\_\_\_\_\_\_\_\_ Color Vision: \_\_\_\_\_\_\_\_\_\_\_\_\_

URINALYSIS: Sp.Grav. \_\_\_\_\_\_\_\_\_\_\_ Alb \_\_\_\_\_\_\_\_\_\_\_ Sugar \_\_\_\_\_\_\_\_\_\_\_ Micro \_\_\_\_\_\_\_\_\_\_\_

Pre-Physical Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHECK (√) if normal: Mark (X) if abnormal:

HEAD-NECK □ CHEST □ ABDOMEN □

GLANDS □ LUNGS □ GENITO-URINARY □

MOUTH-THROAT □ HEART □ SKIN-SCARS □

NOSE □ VESSELS □ EXTREMITIES □

EYES □ JOINTS □ SPINE-MOTION □

EARS □ PHSYCHIATRIC □ NEUROLOGICAL □

TEETH-GUMS □

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DETAIL ABNORMAL FINDINGS:

LIMITATIONS:

Signature of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_