EASTERN NEW MEXICO UNIVERSITY COMMUNICATIVE DISORDERS PROGRAM

Student's Name___________________________ **Date of Birth:**_________________________

Phone Number :(______)__________________ **Student ID #:**_________________________

E-mail:___________________________________ **Expected Date of Graduation:**__________

PLEASE COMPLETE THIS BEFORE GOING TO YOUR PHYSICIAN FOR EXAMINATION

REPORT OF MEDICAL HISTORY

PERSONAL HISTORY (please check if you have had or receive(d) treatment for any of the following)

- ❑ Acne
- ❑ Anemia
- ❑ Anxiety (chronic)
- ❑ Arthritis
- ❑ Asthma/lung disease
- ❑ Alcohol Abuse
- ❑ Appendectomy
- ❑ Back Problem
- ❑ Blind/visual impairment
- ❑ Blood Disorder
- ❑ Cancer/malignancy
- ❑ Cerebral Palsy
- ❑ Chronic Fatigue
- ❑ Deaf/Hearing Impairment
- ❑ Depression
- ❑ Diabetes
- ❑ Eating Disorder
- ❑ Emotional/Mental Illness
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting Spells
- ❑ Muscle Disorder
- ❑ Frequent Cough
- ❑ Gastrointestinal Issues
- ❑ Glasses/Contact Lens
- ❑ Head Injury/Concussion
- ❑ Hearing Aid(s)
- ❑ Heart Problem/Murmur
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ HIV infection/disease
- ❑ Infectious Mononucleosis
- ❑ Impaired mobility/paralysis
- ❑ Kidney Problems
- ❑ Liver disorder
- ❑ Lyme Disease
- ❑ Malaria
- ❑ Meningitis
- ❑ Mumps/Measles/Rubella
- ❑ Migraine/Severe Headaches
- ❑ Multiple Sclerosis
- ❑ Night Sweating
- ❑ Other Neuromuscular Disease
- ❑ Phlebitis/Deep Vein Clot
- ❑ Pneumothorax
- ❑ Positive TB Test
- ❑ Recent Weight Gain or Loss
  - How many _____ lbs.
- ❑ Reflux (chronic)
- ❑ Scarlet/Rheumatic Fever
- ❑ Seizures
- ❑ Sickle Cell Disease
- ❑ Sinusitis
- ❑ Skin Disorder
- ❑ Substance Abuse
- ❑ Thyroid Disease Tonsillitis (Chronic)
- ❑ Tobacco use
  - Smokeless/Chewing
    - How often _____
    - How much _____
  - Cigarettes/Cigars/Pipe
    - How many years _____
    - How many a day _____
- ❑ Tuberculosis
- ❑ Ulcer/Stomach problem
- ❑ Unexplained Aches & Pains
- ❑ UTI's (frequent)
- ❑ Other ____________________
  ____
  ____
  ____

Other medical or psychological conditions that you believe we should be aware of? (Please explain) _______________________
____

List any allergies ____

Have you ever been hospitalized? Had any operations? (Please note details) _______________________________
____

List all current medications ____

List any serious injuries ____

FAMILY HISTORY

	AGE	STATE OF HEALTH	OCCUPATION	AGE OF DEATH	CAUSE OF DEATH
Father					
Mother					
Brother(s)					
Sister(s)					

Has any of your immediate family ever had any of the following? (Please state relationship)

Cancer ________________________________ Diabetes ________________________________

Heart Disease ___________________________ High Blood Pressure _______________________

Kidney Problems ________________________ Tuberculosis ____________________________

Other ____

I hereby certify that the information submitted on this record is complete and correct.

_________________________________ _________________________

Student Signature Date

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PHYSICAL EXAMINATION FORM

A physical examination is required and must be completed and signed by appropriate personnel

Student's Name________________________________ **DOB:**__________________________

(The following to be completed only by MD, DO, PA or NP)

DATE OF EXAM:________________

Height:___________ **Weight:**____________ **BP:**____________ **Pulse:**__________**Vision: R 20/ L 20/**

SYSTEM	NORMAL	DESCRIBE ABNORMALITY
Skin		
HEENT		
Lungs/Chest		
Heart/Vascular/Circulatory		
Abdomen (rectal if indicated)		
Genito-urinary		
Gastrointestinal		
Pelvic (if indicated)		
Musculoskeletal		
Metabolic/Endocrine		
Neurological		
Psychological		
Other:		

CURRENT & CHRONIC PROBLEMS

1.______________________________ 2.________________________________ 3. ______________________________

IF THE STUDENT IS UNDER CARE FOR A CHRONIC OR SERIOUS ILLNESS, PLEASE ATTACH ADDITIONAL CLINICAL REPORTS TO ASSIST US IN PROVIDING CONTINUITY OF CARE.

CURRENT MEDICATIONS: ____

ALLERGIES TO MEDICATIONS: ____________________________________ Type of reaction: ______________

ALLERGIES TO OTHER THINGS: ___________________________________ Type of reaction:______________

RECOMMENDATIONS FOR PHYSICAL ACTIVITY: ☐ Unlimited ☐ Limited (specify):____________________

Based on my assessment of this student's physical and emotional health completed on ______________________(date),

he / she appears able to participate in the activities of a health profession in a clinical setting. Yes _______ No _______

If no, please explain ____

____ ______________________
Signature of Physician/Physician Assistant/ Nurse Practitioner Date

____ ______________________
Print name of Physician/Physician Assistant/ Nurse Practitioner (Area Code) Phone Number

___________________________________ _______________ ___________ ___________
Office Address City State Zip Code