

EMS EDUCATION - HEALTH HISTORY & PHYSICAL

Date of exam: _____

CU STUDENT I.D.# _____

Name _____ Gender _____ Date of Birth ____/____/____ Height _____ Weight _____

Home address _____

Home phone _____ Campus phone _____ SS# _____

In case of emergency, contact: Name _____ Relationship _____

Phone (h) _____ (w) _____ Fax# _____ E-mail _____

Part I: PERSONAL HEALTH HISTORY

EXPLAIN "YES" ANSWERS BELOW. CIRCLE QUESTION IF YOU ARE UNSURE OF THE ANSWER.

- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Do you have an ongoing or chronic illness? | <input type="checkbox"/> | <input type="checkbox"/> | 6. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized overnight? | <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you cough, wheeze, or have trouble breathing during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | Do you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any serious accidents? | <input type="checkbox"/> | <input type="checkbox"/> | Do you have seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you presently under the care of a physician? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| <p><u>List any medications you are currently taking:</u></p> <p>_____</p> <p>_____</p> | | | <p><u>List any allergies: DRUG, FOOD, INSECTS, ENVIRONMENT:</u></p> <p>_____</p> <p>_____</p> <p>_____</p> | | |
| 3. Have you ever passed out? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Have you ever had eating disorders/weight problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Have you ever had TB or any other communicable disease or exposure? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you get tired more quickly than your friends do during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a positive reading on a tine, PPD, or TB skin test? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you have arthritis/bone problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had high blood pressure or high cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> | 11. FEMALES: Do you have menstrual difficulties? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you have a history of substance abuse? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever had emotional/mental health problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Any immediate family history of diabetes, heart disease or high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Are there any other medical conditions or concerns? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | <input type="checkbox"/> | <input type="checkbox"/> | <p>If YES, to any questions, please explain here: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> | | |
| 5. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Have you ever been knocked out, become unconscious, or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I hereby grant permission for this form to be sent to the Cedarville University EMS Education Department upon completion.

Signature _____ Date _____

NAME: _____ ID#: _____

PART II: IMMUNIZATION STATUS: (to be completed by Physician or Practitioner)

Current immunization protection is required for all students. Obtain appropriate immunizations to meet CDC recommendations.

IMMUNIZATION HISTORY

	Date or Age	Immunization (Date/s)			Booster (Date)	Titer Results & Date (if indicated)	
Tetanus/Diphtheria (within 10 years)							
MMR # 1							
MMR # 2							
Hepatitis B (2shots prior to Fall term)		1	2	3			
Polio Oral/Salk							
Rubeola (if no MMR)		1	2				
Rubella (if no MMR)		1	2				
Varicella (Chickenpox)		1	2				
Mantoux (TB)		Date	Result in mm			X-ray	Results
BCG							

PART III : PHYSICAL EXAMINATION: (to be completed by Physician or Practitioner)

Pulse _____	BP _____ / _____	Vision: R 20/_____ L 20/_____
Corrected: <input type="radio"/> YES <input type="radio"/> NO	Pupils: Equal _____ Unequal _____	

	NORMAL	ABNORMAL FINDINGS	INITIALS	INITIALS
MEDICAL				
Appearance				
Eyes/Ears/Nose/Throat				
Lymph Nodes				
Heart				
Pulses				
Lungs				
Abdomen				
Genitalia (males only)				
Skin				
MUSCULOSKELETAL/NEUROLOGICAL				
Neck & Back				
Shoulder / Arm / Hand				
Hip / Leg / Ankle				
Foot				
Nervous System				

- Cleared to participate in EMT Program Clinicals
 - Cleared after completing : _____
 - NOT** cleared to participate in EMT Program Clinicals
- Reason: _____
- Recommendations: _____

Signature of Physician✕ _____ Date: _____
 Physician(print/type) _____