Broward College
Medical History and Physical Examination UPDATE Form

In order to continue to participate in the clinical portion of any health science program, the student must complete a Medical History and Physical Examination Update form. Documentation, such as lab results must be attached to the form.

Be certain to take all documentation of immunizations with you to your physical examination so that the form can be completed correctly. Failure to submit the original form - complete with documentation - may prevent you from progressing to the clinical portion of your program.

To assist the student and the Health Care Examiner - MD, DO, nurse practitioner (ARNP) or physician assistant (PA) - in completing this form, instructions are provided below. **Students are responsible for the cost of the physical examination and any related expenses.**

Section 1:
Student Self-Report of Medical History
Student Statement
This section must be reviewed and signed by the student.
This section, wherein information about past and current health status is detailed, should be completed by the student **prior** to having a physical examination. **Be sure to include the name of the program on each of the pages of the form.**

Section 2:
Physical Examination
Laboratory Findings
Health Care Examiner's Statement
This section is to be completed by the Health Care Examiner (MD, DO, ARNP and PA only). Review of the program's Technical Performance Standards is required. All sections must be completed with a signature provided.

The Health Care Examiner will review any documentation the student provides as related to tuberculosis.

Tuberculosis

- ✓ Documentation of PPD skin test results indicating negative reactivity reported within three months of the physical examination **or**
- ✓ Evidence of a chest x-ray within three months of the physical examination and medical treatment for those with positive reactivity or past history of positive reactivity.

Submit the completed form – pages 1 and 2 – with all required documentation submitted to the appropriate program representative.

Prior to submitting the form, please make copies for your own records.

Section 1: Student Self-Report of Medical History

Last Name	**First Name**	**Student ID #**
Emergency Contact Name	**Relationship**	**Contact at:**
Email Address		

Annual Update of Review of Systems / Medical History — please check all that apply			
Abnormal Bleeding		Hepatitis	
Allergies		Hernia	
Anemia		High Blood Pressure	
Anxiety		High Cholesterol	
Arthritis		Intestinal / Stomach Trouble	
Asthma		Low Back Condition / Scoliosis	
Cancer of _____		Mononucleosis	
Chest Pain		Neck Condition	
Chronic Cough		Neurological Disorder	
Concussion / Head Injury		Orthopedic Disorder	
Emotional Disturbance		Prior Surgery	
Depression		Rheumatic Fever	
Diabetes		Seizure Disorder	
Ear Trouble / Hard of Hearing		Sickle Cell Trait	
Eating Disorder		Sinus Problems	
Eye Trouble / Vision Loss		Skin Disease	
Fracture of _____		Splenectomy	
Gallbladder Disease		Sprain of _____	
Headaches / Migraines		Syncope / Fainting	
Heart Murmur or Arrhythmia		Thyroid Disease	
Heart Problems (other)		Tuberculosis	

Please indicate any health concerns, if any, that you presently have:

_____

_____

_____

_____

Student Statement

The information provided on the Medical History and Physical Examination Update form is accurate to the best of my knowledge. I have attached required results of any laboratory test.

I am aware that the Medical History and Physical Examination Update form will be reviewed and will be returned to me if there are any incomplete sections or if additional documentation is requested.

I understand that failure to complete the form correctly may jeopardize my participation in the clinical portion of the program.

Student Signature: Date:

Information detailed on the Medical History and Physical Examination form is legally privileged and confidential. It is intended for use by the Health Science program unless written consent has been provided for release to other parties.

Section 2: Physical Examination

Examiner: Please examine this student as you would for a routine check-up. This student will be working closely with people in various health care settings.

HEIGHT: _____ **WEIGHT:** _____ **BLOOD PRESSURE:** _____ **PULSE** _____

SYSTEM	NORMAL	FINDING	COMMENTS/PREVIOUS CONDITIONS/SURGERY
Cardiovascular			
Endocrine/Metabolic			
Eyes/Ears/Nose /Throat			
Gastrointestinal			
Genitourinary			
Integumentary			
Musculoskeletal			
Neurological			
Respiratory			

Is the student under treatment for any medical, surgical or emotional condition? **YES** **NO**
If yes, please provide details:

_____

Is the student now taking any medications? **YES** **NO**
If yes, please list:

_____

Does the student require any follow-up health supervision? **YES** **NO**
If yes, please specify:

_____

Mantoux PPD – Tuberculin Test – required annually	
Test Date:	Attach results of laboratory test
If result of tuberculin test is positive, a chest X-ray is required.	
Chest X-ray Date:	Attach results

I have verified that the individual I have examined is the named individual on this form and that the above tests/vaccinations were performed in this office/laboratory.

Examiner's Name (Please print) _____
License # _____ **Phone** _____

Signature of Health Care Examiner _____ **Date** _____

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