### Medical History & Physical Exam Update Form

**BROWARD COLLEGE HEALTH SCIENCE PROGRAM**

**MEDICAL HISTORY & PHYSICAL EXAM UPDATE FORM**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Student ID #</th>
</tr>
</thead>
</table>

#### Review of Systems / Medical History — please check all that apply

- Abnormal Bleeding
- Allergies – Latex, Penicillin, Ampicillin, Other
- Anemia
- Anxiety
- Arthritis
- Asthma
- Cancer of
- Chest Pain
- Chronic Cough
- Concussion / Head Injury
- Emotional Disturbance
- Depression
- Diabetes
- Ear Trouble / Hard of Hearing
- Eating Disorder
- Eye Trouble / Vision Loss
- Fracture of
- Gallbladder Disease
- Headaches / Migraines
- Heart Murmur or Arrhythmia
- Heart Problems (other)
- Intestinal / Stomach Trouble
- Asthma
- Low Back Condition / Scoliosis
- Hernia
- High Blood Pressure
- High Cholesterol
- Intestinal / Stomach Trouble
- Low Back Condition / Scoliosis
- Mononucleosis
- Neck Condition
- Neurological Disorder
- Orthopedic Disorder
- Prior Surgery
- Rheumatic Fever
- Seizure Disorder
- Sickle Cell Trait
- Sinus Problems
- Skin Disease
- Splenectomy
- Sprain of
- Syncope / Fainting
- Thyroid Disease
- Tuberculosis

#### Mantoux PPD – Tuberculin Test and/or CXR required annually – within past 12 months

<table>
<thead>
<tr>
<th>Mantoux PPD – Tuberculin Test and/or CXR</th>
<th>Attach supporting documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD Test Date</td>
<td></td>
</tr>
<tr>
<td>Date &amp; Time Administered</td>
<td>Administered by</td>
</tr>
<tr>
<td>Manufacture of PPD</td>
<td>Expiration Date Lot Number</td>
</tr>
<tr>
<td>Date Read</td>
<td>Read By</td>
</tr>
</tbody>
</table>

Results in Millimeters of Induration

**If results are positive or restricted from a PPD due to the BCG vaccine, a chest X-ray is required**

<table>
<thead>
<tr>
<th>Chest X-ray Date</th>
<th>Attach Results of Chest X-ray</th>
<th>Examiner’s Initials</th>
</tr>
</thead>
</table>

#### Flu Vaccine - seasonally between September 15 & March 31

<table>
<thead>
<tr>
<th>Flu Vaccine - seasonally between September 15 &amp; March 31</th>
<th>Attach supporting documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Vaccine</td>
<td>Injection Site</td>
</tr>
<tr>
<td>Lot Number</td>
<td>Expiration</td>
</tr>
</tbody>
</table>

Please indicate any health concerns that you presently have and provide information regarding any of the boxes checked above.

____________________________________________________________________________
____________________________________________________________________________
__________________________________________________________________________

*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.*
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. Please indicate/comment on any abnormal findings; using additional sheets if necessary or providing further documentation.

**HEIGHT:** _________    **WEIGHT:** _________    **BLOOD PRESSURE:** _________

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>NORMAL</th>
<th>FINDING</th>
<th>COMMENTS/PREVIOUS CONDITIONS/SURGERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endocrine/Metabolic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes/Ears/Nose/Throat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitourinary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integumentary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Is the student under treatment for any medical, surgical or emotional/psychological condition?**

- **YES**
- **NO**

If yes, please provide details:

________________________________________________________________________________________________________________________________________________________

**Is the student now taking any medications?**

- **YES**
- **NO**

If yes, please list:

________________________________________________________________________________________________________________________________________________________

**Is the student limited from participating in physical activities in the clinical area?**

- **YES**
- **NO**

If yes, please specify limitations:

________________________________________________________________________________________________________________________________________________________

**Does the student require any follow-up health supervision?**

- **YES**
- **NO**

If yes, please specify:

________________________________________________________________________________________________________________________________________________________

**Within the last 5 years, has the student been treated for any substance related (drug/alcohol) disorder?**

- **YES**
- **NO**

If yes, please specify:

________________________________________________________________________________________________________________________________________________________

---

**EXAMINER’S NAME** (PLEASE PRINT) _____________________________________________

**PHONE**  ____________________

**ADDRESS** __________________________________________

**CITY** ________  **STATE** ________  **ZIP** ________

**SIGNATURE OF MD/DO/ARNP** __________________________

**LICENSE #** _______________________________________

**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.*