



Broward Community College Medical History and Physical Examination Form - UPDATE

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 through 3 – with all required documentation submitted to the appropriate program representative.

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

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 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: _____

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

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:

Can student participate in unlimited physical activities in the clinical area? YES NO
 If no, please specify limitations:

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

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Section 2: Physical Examination continued

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

Section 2: Health Care Examiner’s Statement

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 or I have reviewed any documentation relative to the student’s immunization record.

Examiner’s Name (Please print) _____

License # _____ **Phone** _____

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