MEDICAL HISTORY

Name		
Last Name	First Name	Middle Name

CSU ID NUMBER	Gender	Company
	❑Male ❑Female	

PLEASE ANSWER ALL QUESTIONS, IF ANY ANSWER IS YES PLEASE DESCRIBE ON LINE BELOW

CHECK EACH ITEM	YES	NO
1. Are you allergic to any foods or medications? If so, describe below.		
2. Are you currently taking medications? If so, describe below.		
3. Have you had any major injuries or illness? If so, describe below.		
4. Have you been hospitalized or had an operation? If so, describe below.		
5. Have you ever had an occupational illness or injury? If so, describe below.		

CHECK EACH ITEM	YES	NO
6. Have you ever been advised to have an operation? If so, describe below.		
7. Have you ever worked in a hazardous environment such as Asbestos, Lead, Dust, Noise, Chemicals?		
8. Do you or have you ever smoked cigarettes? How long? _____ Drink alcohol? How much? _____		
9. Has any blood relative had: ❑Cancer ❑ Diabetes ❑ Heart Disease ❑ High Blood Pressure ❑ Allergies or Asthma ❑ Mental Illness ❑Tuberculosis		

HAVE YOU EVER HAD OR CURRENTLY HAVE:

CHECK EACH ITEM	Y	N	CHECK EACH ITEM	Y	N	CHECK EACH ITEM	Y	N
10. Recent Gain or Lost weight			27. Nose, Throat, Sinus Trouble			44. Varicose Veins		
11. Weakness, Fatigue, Loss of Appetite			28. Voice Change/ Hoarseness			45. Vomiting of Blood		
13. Nervous Condition, Depression			29. Dental/ Gum Disease			46. Frequent Indigestion		
14. Rashes, Allergies, Hives			30. Recurrent Sore Throat			47. Frequent use of Antacids		
15. Skin Disease			31. Chronic/ Recurrent Cough/ Cold			48. Ulcers		
16. Frequent or Severe Headaches			32. Asthma or Wheezing			49. Change of Bowel Habits		
17. Head Injuries			34. Shortness of Breath			50. Frequent Constipation/ Diarrhea		
18. Epilepsy, Fits, Convulsion			35. Tuberculosis			51. Bleeding from Bowels/ Black Stools		
19. Dizziness/ Fainting Spells			36. Heart Trouble/ Medication			52. Hemorrhoids [Piles]/ Rectal Disease		
20. Eye Injury, Infection, Discharge			37. High Blood Pressure			53. Hernia		
21. Double Vision			38. Chest Pain or Pressure			54. Jaundice		
22. Decreased Vision or Blindness			39. Palpitation/ Pounding Heart			55. Diabetes/ High Blood Pressure		
23. Ear Pain, Infection, Discharge			40. Swelling Feet/Ankles			56. Kidney/ Bladder Infection/ Stone		
24. Loss of Hearing			41. Scarlet or Rheumatic Fever			57. Venereal Disease		
25. Broken Bones/ Joint Dislocation			42. Pain Stiffness of Neck/ Back			58. Blood/ Sugar/ Protein in Urine		
26. Arthritis/ Rheumatism / Bursitis			43. Pain in Shoulders/ Arms/ Hands			59. Foot Trouble		

FEMALE PATIENTS COMPLETE AREA BELOW

CHECK EACH ITEM	Y	N	CHECK EACH ITEM	Y	N	CHECK EACH ITEM	Y	N
61. Female Disorder Treatment			64. Duration of Periods			67. Number of Pregnancies		
62. Irregular Menstruation			65. Date of Last Smear			68. Number of Living Children		
63. Painful Menstruation			66. Date of Last Period			69. Are You Pregnant?		

PRIMARY CARE PHYSICIAN

Name _____

Address _____

Phone

I hereby certified that to the best of my knowledge, the foregoing answers are complete and correct.

Print Applicant/Student Name | Signature of Applicant/Patient | Date

Print Provider Name | Signature of Provider | Date

GENERAL PHYSICAL EXAM

Date | Last Name

Vital Signs						
BP	Pulse	Temp	RR	Weight	Height	BMI

Distance Vision: Uncorrected			Distance Vision: Corrected			Near Vision: Uncorrected			Near Vision: Corrected		
Right	Left		Right	Left		Right	Left		Right	Left	

Clinical Evaluation (√ = Normal ; X = Abnormal ; N= Not exanimated ; N/A= Does not apply)

Organ System	Code	Comments	Organ System	Code	Comments
Skin			Hands/ Wrist		
Lymphatics			Hip/ Knee		
Head/ Neck			Ankle/ Feet		
Eyes			Cervical Spine		
Ears			Thoriac Spine		
Nose			Lumber Spine		
Throat, Mouth, Tongue			Gait		
Teeth			Cranial Nerves		
Chest/ Lungs			Reflexes		
Heart			Babinski		
Murmurs/ Thrills/ Heaves			Romberg		
Breast/ Nipples			Hoffman		
Abdomen/ Liver/Spleen			Motor Strength		
Hernia			Tremors		
Inguinal Nodes			Rectal/ Prostate		
Shoulders			Emotion Status		
Arms/ Elbow			Other		

Labs		Radiology		Cardiology	
CBC		Chest X- Ray		EKG	
CMP, LIPID, TSH		MRI		2- D Echocardiogram	
PSA		CT SCAN		Exercise Stress Test	
Vitamin D		Mammogram			
Other		Other			

Option Labs

Urinalysis					
Glucose	Bilirubin	Ketone	S. Gravity	Blood	PH
Protein	Nitrite	Leukocytes		Color	UROB

General Appearance		
Good	Fair	Poor

DIAGNOSIS	PLAN

Physician Signature | **Date**