ROANE STATE COMMUNITY COLLEGE
Health Information Management Department

STUDENT NAME: _____

THIS PHYSICAL EXAMINATION FORM MUST BE COMPLETED AND FILED WITH THE HIM DEPARTMENT PRIOR TO Any Clinical Visit

To be completed and returned by a licensed physician or certified nurse practitioner:

PHYSICIAN'S NAME: _____

BUSINESS ADDRESS: _____

CITY_____STATE_____ZIP_____PHONE_____

PHYSICAL EXAMINATION:

Height _____Weight _____ Blood Pressure _____Pulse_____

Vision Acuity/Depth Perception/Peripheral Vision/Color Vision_____

Hearing _____Neurological Status_____

Abdomen (pain, scars, masses) _____Skin_____

Skeletal system_____Posture_____

Heart _____Lungs _____Varicosities or Hemorrhoids _____Hernia_____

Urinalysis: Glucose/Albumin/Blood_____

Must have annual Tuberculosis skin test or chest x-ray if TB skin test positive
*TB Skin Test: _____/_____ or Chest X-Ray:_____/_____
Date Results Date Results

Immunization Dates: All immunizations must be up to date according to the regulations of the United States Health Department. Give date of most recent immunization.

*Measles/Mumps/Rubella Titer_____. **Medical proof of immunity** or updated immunization is **required prior to clinical rotations**. (2 doses per CDC requirements)
Tetanus (Tdap): _____ (needed every 10 years)
Hepatitis B: _____ (3 doses per CDC requirements) or titer (Documentation must be submitted when injections are received until series is completed.)
Varicella _____, history of varicella, documentation of vaccine or titer (2 doses if after 13th birthday)
Flu Immunization (annual): _____

IMMUNIZATIONS MAY BE OBTAINED AT THE HEALTH DEPARTMENT IN MOST COUNTIES. MMR vaccines may require a fee and may only be available at private physician's office.

Please comment on the physical/psychological capability of this student regarding entrance into the Health Information Management program:

_____

_____
Signature of physician or certified nurse practitioner Date of exam

ROANE STATE COMMUNITY COLLEGE
MEDICAL HISTORY AND PHYSICAL EXAMINATION
REPORT OF APPLICANT

NAME_____
LAST FIRST MIDDLE

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE (_____)_____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?

NAME_____ Relationship _____EMERGENCY PHONE _____

ADDRESS_____

MEDICAL HISTORY (To Be Completed by Applicant)

1. Have you had any of the following?

____Asthma ____Eye or Vision problems ____Kidney Disease ____Broken bones
____Epilepsy or seizures ____Rheumatic Fever ____Chest pain ____Heart trouble/murmur
____Rupture/hernia ____Chronic cough ____Head Injury ____Sinus Trouble
____Diabetes ____Jaundice ____Tuberculosis ____Hearing problem

2. Have you ever had chickenpox? Yes ____ No ____ Unsure ____
Have you had varicella (chickenpox) vaccine? _____

3. Are you allergic to any medicines? _____. If so, please list them:

_____

4. List any additional illnesses, operations or injuries and give the dates and treatment you received:
_____

_____

5. At present, are you taking any medications, or receiving any medical treatment? _____. If so, please list:

_____

_____

6. Have you had any emotional problems? _____. If so, list treatment received:
_____

_____

7. Do you need special assistance in moving about our facilities such as the use of the elevator, etc.?

_____

APPLICANT'S SIGNATURE_____