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BOSTON BAPTIST COLLEGE

Student Medical Examination Record Form

Student Information

Last Name:____________________ First Name:__________________ Middle Initial: ____

Home Address: ____

City:______________________________ State:__________ Zipcode:______________

Phone:________________________ Email:______________________________________

SSN:____________________________ DOB: _______/_______/___________ Sex:____

Emergency Contact Information

Last Name:____________________ First Name:__________________ Middle Initial: ____

Relationship to Student:____

Phone:________________________ Email:______________________________________

Student Medical History

Please check all that apply to you.

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Appendectomy
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chest Pain
- ☐ Chills
- ☐ Chronic Colds
- ☐ Chronic Cough
- ☐ Chronic Swelling
- ☐ Constipation
- ☐ Convulsions
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Ear Infection
- ☐ Eczema
- ☐ Epilepsy
- ☐ Excessive Fatigue
- ☐ Fainting
- ☐ Fever
- ☐ Head Injury
- ☐ Heart Disease
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Insomnia
- ☐ Joint Problems
- ☐ Kidney Stones
- ☐ Low Blood Pressure
- ☐ Malaria
- ☐ Meningitis
- ☐ Nausea
- ☐ Nervousness
- ☐ Paralysis
- ☐ Pneumonia
- ☐ Seizures
- ☐ Sexually-Transmitted Disease
- ☐ Shortness of Breath
- ☐ Sickle Cells
- ☐ Sinusitis
- ☐ Thyroid Issues
- ☐ Tremors
- ☐ Ulcers
- ☐ Urinary Tract Infection
- ☐ Vomiting

Are you allergic to any foods, medications, or other substances? ☐ Yes ☐ No

If yes, please list your allergies: ____

Student Signature:______________________________________ Date:_____/_______/_______

Physical Examination Form (For Medical Professionals Only)

Patient's Full Name: ______________________________

DOB: ____/____/________ Date of Examination: ____/____/________

EVALUATIONS

VITAL SIGNS

Blood Pressure	
Temperature	
Pulse	

IMMUNIZATIONS REPORTS & TESTING

Required Vaccinations & Testing

- Varicella (Chickenpox) ☐ ☐
- Tetanus (Td/Tdap) ☐
- MMR ☐ ☐
- Tuberculosis Questionnare ☐
- Meningococcal (MenACWY) ☐
- Hepatitis B Series ☐ ☐ ☐
- Influenza ☐

Notes: ______________________________

GENERAL APPEARANCE

	Normal	Abnormal		Normal	Abnormal
Skin	☐	☐	Respiratory	☐	☐
Eyes	☐	☐	Muscular	☐	☐
Ears	☐	☐	Gastrointestinal	☐	☐
Nose	☐	☐	Skeletal	☐	☐
Throat	☐	☐	Lymphatic	☐	☐
Cardiovascular B/P	☐	☐	Extremities	☐	☐
Chest	☐	☐	Neurological	☐	☐
Abdomen	☐	☐	Dental	☐	☐

VISUAL ACUITY

Does the patient use corrective lenses? ☐ Yes ☐ No

Is the patient considered legally blind? ☐ Yes ☐ No

Do you recommend a Physical Activity Restriction for this patient? ☐ Yes ☐ No

Please list **all** current medications for this patient: ______________________________

____

Does this patient have a history of drug and/or alcohol abuse? ☐ Yes ☐ No

Student Signature: ______________________________ Date: ____/____/________

License Number/Clinic Stamp: ______________________________