St. Petersburg College

HEALTH EXAMINATION FOR HEALTH OCCUPATION PROGRAMS

NAME: Last ______ First ______ Middle initial ______ Student number ______

Program applying for ______

TO THE PHYSICIAN: The patient requesting this health examination is an applicant to one of the health occupation programs at St. Petersburg College. The purpose of the examination is to ascertain whether the applicant's health is adequate to enter occupational programs requiring physical and emotional stamina, and contact with patients in clinical settings. Should you have questions regarding this form, please call or write the director of the health program to which your patient is applying. **Thank you for your assistance.**

TO BE COMPLETED BY A LICENSED HEALTH PRACTITIONER (M.D., D.O., A.R.N.P., P.A.)

Height:	Weight:	Pulse:	Blood pressure:

Health history: To be completed by practitioner. Please describe all significant findings under Physician's Comments.

Yes	No		
☐	☐	1.	Eye or vision problems
☐	☐	2.	Ear or hearing problems
☐	☐	3.	Mouth or teeth problems
☐	☐	4.	Ear, nose, throat
☐	☐	5.	Cough, sputum, difficulty breathing
☐	☐	6.	Breast lumps, enlargements, nipple drainage
☐	☐	7.	Heart disease/hypertension
☐	☐	8.	Swollen lymph nodes
☐	☐	9.	Indigestion, pain or food intolerance
☐	☐	10.	Bowel-constipation, diarrhea
☐	☐	11.	Hepatitis (If yes, type _____)
☐	☐	12.	Back pain or surgery
☐	☐	13.	Muscle pain, weakness
☐	☐	14.	Foot problems
☐	☐	15.	Headaches or seizure
☐	☐	16.	Skin rashes, lesions
☐	☐	17.	Urinary problems
☐	☐	18.	Rectal problems
☐	☐	19.	Female: vaginal discharge, excessive bleeding
☐	☐	20.	Male: prostate problems
☐	☐	21.	Emotional illness
☐	☐	22.	Diabetes
☐	☐	23.	Allergies
☐	☐	24.	Chemical dependency/substance abuse
☐	☐	25.	Other : ____________________

Check each item below: To be completed by practitioner.

Normal	Abnormal		
☐	☐	1.	Ears, hearing
☐	☐	2.	Oral cavity: hard and soft tissue
☐	☐	3.	Nose, throat and sinuses
☐	☐	4.	Lungs
☐	☐	5.	Breasts
☐	☐	6.	Heart-size, rhythm and sound
☐	☐	7.	Lymph nodes
☐	☐	8.	Abdomen
☐	☐	9.	Back
☐	☐	10.	Upper extremities
☐	☐	11.	Lower extremities
☐	☐	12.	Feet and arches
☐	☐	13.	Reflexes
☐	☐	14.	Skin
☐	☐	15.	Genitalia
☐	☐	16.	Anus
☐	☐	17.	Posture
☐	☐	18.	Pelvic exam
☐	☐		
☐	☐		
☐	☐		
☐	☐		
☐	☐		
☐	☐		

Describe any abnormalities. Precede each comment by number referring to appropriate item.

Visual exam: Distance: OD ______ OS _____ Near: OD ______ OS _____ Color perception _____________

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Does applicant have any current or past emotional illness? ☐ Yes ☐ No If yes, give dates(s) and describe treatment.

Has applicant had any medical/surgical problem that has required treatment in the past two years?

☐ Yes ☐ No If yes, date: ______________ If yes, describe:

Does applicant have any current or past chemical dependency/substance abuse problem? ☐ Yes ☐ No
If yes, list dates and describe treatment.

Please list any medication the patient is taking on a continuing basis:

IMMUNIZATION / SCREENING HISTORY

Tuberculin test within last 12 months. If initial testing, two step, 1-3 weeks apart. Date #1 _______________ Result: ( ) Positive ( ) Negative If initial testing, Date #2 _______________ Result: ( ) Positive ( ) Negative OR A single Quantiferon-TB Gold Test Date: _____ Result: ______ If screening test is positive, chest x-ray is required.	Hepatitis B vaccine Date #1: ___________ Date #2: ___________ Date #3: ___________ Documentation of all 3 is required. Titer recommended 1-2 months following completion of series. Date: ___________ Result: ___________	MMR (2 doses, 4 weeks apart) Date #1: ______________ Date #2: ______________ OR these 3: Measles titer Date: ______ Result: ______ Mumps titer Date: ______ Result: ______ Rubella titer Date: ______ Result: ______	Td (tetanus) booster (within last 10 years) Date: ________________ Varicella titer Date: ________________ Result: ________________ If not immune, 2 doses of varicella vaccine at least 28 days apart. Date #1: ______________ Date #2: ______________

PHYSICIAN'S COMMENTS: Include any additional significant information concerning health findings and/or treatment.

To the best of my knowledge, applicant appears to be free of infectious disease. My signature indicates that I believe this applicant's health history and physical examination findings justify him/her to undertake a health program, which includes class and clinical practice. ☐ Yes ☐ No

Health practitioner's signature and license Date

Health practitioner's name (printed)

ADDRESS: Street City State Zip Code

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