

PHYSICAL EXAM FORMS

Occidental College – Emmons Health Center – 1600 Campus Rd. Los Angeles, CA 90041 O. 323-259-2657, F. 323-341-4970

Please Print Last Name _____ First _____ Date of Birth _____

HEALTH HISTORY To be completed by student

LAST NAME (PRINT), FIRST, MIDDLE	GENDER: F <input type="checkbox"/> M <input type="checkbox"/> T,I <input type="checkbox"/>
HOME ADDRESS	DATE OF BIRTH
HOME CITY, STATE, ZIP	ENTERING OXY AS A: Fr <input type="checkbox"/> So <input type="checkbox"/> Jr <input type="checkbox"/> Sr <input type="checkbox"/>
EMAIL ADDRESS	MOBILE PHONE ()

In Case of Emergency, Contact:

LAST NAME (PRINT), FIRST, MIDDLE	RELATIONSHIP	HOME PHONE ()
HOME ADDRESS		BUSINESS PHONE ()
HOME CITY, STATE, ZIP		MOBILE PHONE ()

Family Health History

Has anyone in your biological family had any of the following?	Yes	No	Age Diagnosed	Relationship
Asthma				
Cancer (specify type)				
Diabetes				
High blood pressure/high cholesterol				
Heart attack or other heart problems				
Stroke				
Mental Illness				
Alcohol/chemical or drug dependency				
Other				

Personal Health History

Have you experienced, or are now experiencing any of the following?	Have you received treatment?		Did your treatment include: (Please check all that apply)			Date of treatment & Notes
	Yes	No	Yes	No	Counseling Medications List medication(s)	
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> _____	
Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> _____	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> _____	
Obsessive Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> _____	
Panic disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> _____	
Phobia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> _____	
Suicide attempt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> _____	
Anoxeria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> _____	
Binge or compulsive eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> _____	
Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> _____	
Schizoaffective disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> _____	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> _____	

Do you plan to continue, resume or begin receiving care for these problems while at Oxy? Yes No

Describe _____

TOBACCO USE: Yes No If Yes, ___ pack(s) per day for _____ years.

ALCOHOL USE: Yes No How often? _____ Average # of drinks on each occasion? _____

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Have you experienced, or are now experiencing any of the following?							
	ADD/ADHD		GERD		Palpitations		*Surgery (describe below)
	Anemia		Hay fever		Pneumonia		
	Asthma		High blood pressure		Prostheses		
	Chicken pox		High cholesterol		Rheumatism or arthritis		*Fracture (describe below)
	Colitis/Crohn's disease		Irritable bowel syndrome		Scarlet fever		
	Convulsions/seizures		Malaria		Skin disorders		*Heart Condition/murmur (describe below)
	Diabetes		Marfan's syndrome		Stomach or duodenal ulcer		
	Ear, nose & throat problems		Migraine/chronic headache		Tuberculosis		Other (specify)
	Excessive fatigue		Measles/Mumps/Rubella		Urinary tract infection		
	Glasses/contact lenses		Mononucleosis				

*Describe any surgeries, fractures, heart conditions with date of onset and treatment and current care (if applicable): _____

List any illness, condition or injury, not listed above, for which you are now being treated: _____

List any medications you take routinely (including birth control pills and non-prescription medications including nutritional supplements): _____

ALLERGIES: Yes No (Please list any allergies to medications, foods, insect stings, pollen or other environmental factors.) _____

1. Yes No Has your doctor denied or restricted your participation in sports for any reason? _____
2. Yes No Have you ever passed out or nearly passed out during or after exercise? _____
3. Yes No Have you ever experienced excessive shortness of breath or pain, discomfort or pressure in your chest during exercise? _____
4. Yes No Does your heart race or skip beats during or after exercise? _____
5. Yes No Have you ever had a neck or back injury? _____
6. Yes No Does any family member have heart problems or have died from heart problems or sudden death before age 50 or become disabled? _____
7. Yes No Have you had any test on your heart including EKG, echocardiogram or others? If Yes, when was it done? _____
What were the results? _____
8. Yes No Have you ever had a head injury or a concussion? If Yes, how many times? ____ When was the most recent occurrence? _____
9. Yes No Do you have a seizure disorder? If Yes, when was your most recent occurrence? _____
10. Yes No Do you cough, wheeze or have difficulty breathing during and after exercise? _____
11. Yes No Do you have severe muscle cramps or become ill when exercising in heat? _____
12. Yes No Do you have a regular menstrual period? (females) When was your last menstrual cycle? _____

IMPORTANT INFORMATION – PLEASE READ AND COMPLETE

Statement by Student: I have personally supplied the above Health History Information and attest that it is true and complete to the best of my knowledge. I understand that this information is strictly confidential and will not be released to anyone without my written consent unless by court order. However, if I should be ill or injured and unable to sign the appropriate forms, I hereby give my permission to the Emmons Health Center healthcare providers to release information from my health record to another provider(s), hospital, or other medical agency involved in providing me with emergency treatment and/or care.

STUDENT SIGNATURE (REQUIRED)

DATE

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PHYSICAL EXAM To be completed by the PROVIDER (MD, DO, NP, PA)

Patient Last Name _____ First _____ M F T/I Date _____

Date of Birth _____ Year in School: FR SO JR SR Sport (if applicable) _____

Height _____ Weight _____ % of Body Fat (optional) _____ Pulse _____ BP ____/____/____ Temp _____

Vision R 20/____ L 20/____ Corrected: Y N Pupils: Equal _____ Unequal _____

Objective	Normal	Abnormal	Description/Notes
Skin/body marks			
Eyes, Ears, Nose			
Pulse (femoral)			
Mouth, teeth, & throat			
Neck			
Chest/lungs			
Abdomen			
Heart/Murmurs			
Genitourinary (males)			
Neurological			
MUSCULOSKELETAL			
Appearance			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

**EKG – only if indicated. Normal Abnormal (specify) _____

This Physical Exam is for (select all that apply): **New Student** **NCAA Sports** **Club Sports** **Study Abroad**

Please check one of the following boxes if this Physical Exam is also being used to CLEAR a student to participate in athletic sports or travel for a study abroad program.

This student is **CLEARED** to participate in Athletics or Sports and/or travel for a Study Abroad Program in _____ (country).

This student is **CLEARED** to participate in Athletics or Sports and/or travel for a Study Abroad Program in _____ (country)

ONLY if the FOLLOWING RECOMMENDATIONS are met : _____

This student is **NOT CLEARED** to participate in Athletics or Sports and/or travel for a Study Abroad Program.

Provider Name (print/type) _____ Date _____

Address _____ Phone _____

Provider Signature _____ MD, DO, NP, PA