ALABAMA AGRICULTURAL AND MECHANICAL UNIVERSITY
Student Medical Examination Record Form

Medical History Form

Demographic Information

Last Name: _____First Name: _____ Middle: _____
Home Address: _____City:_____State:_____Zip:_____
Home Phone: _____ Alternate Phone: _____
Social Security Number: _____Date of Birth: _____ Gender: _____
For Emergency Notify: _____ Relationship: _____
Home Phone: _____Work: _____ Cell: _____

Student Medical History

Please check Y (yes) and N (no) for each condition.

	Y	N		Y	N		Y	N		Y	N
Allergies			Bronchitis			Head Injury			High or low Blood Pressure		
Chills			Joint Problems			Seizures			Fever		
Sinusitis			Hemorrhoids			Back Pain			Kidney Stones		
Paralysis			Dizziness			Ear Infections			Excessive Fatigue		
Anemia			Chest Pain			Heart Disease			Chronic Swelling		
Diabetes			Cancer			Tremors			Shortness of breath		
Thyroid			Convulsions			Vomiting			Sexually Transmitted Disease		
Anxiety			Meningitis			Epilepsy			Frequent Urinary Tract Infections		
Eczema			Depression			Chronic Cough			Sickle Cell		
Arthritis			Constipation			Chronic Colds			Diarrhea		
Nausea			Fainting			Pneumonia			Hernia		
Insomnia			Dizziness			Malaria			Heartburn		
Asthma			Nervousness/panic			Appendectomy			Ulcers		

Are you allergic to any foods, medications, or other substances? Yes___ No___ if yes, please list: _____

_____ _____
Student Signature Date

*The Medical Form must be completed by the student and the Physical form, completed by a doctor. Forms may be returned to our office, via: FAX, MAIL, SCAN to E-MAIL, OR HAND DELIVERED. Please use the envelope provided stamped **CONFIDENTIAL MAIL** to return a copy of your primary insurance card, this form, and all other necessary forms.
RETURN COMPLETED FORM TO:

Alabama A&M University
P.O Box 98
Normal, Alabama 35762

Physical Examination Form

Patient's Full Name: _____ **DOB:** _____ **Today's Date:** _____

Evaluations

Vital Signs			Laboratory Results and Immunizations Report		
	Normal	**Abnormal**	Hct _____ Hgb _____	**Normal**	**Abnormal**
Blood Pressure					
Temperature			*Fasting Blood Glucose*		
Pulse			*Urinalysis*		
Weight			**Required Vaccinations**		
Height			*Varicella (Chickenpox)*		
Mood			*Tetanus (Td/Tdap)*		
Recommended Vaccinations ✓ Meningitis (Incoming Freshmen) ✓ Hepatitis B Series ✓ HPV			*MMR*		
			Tuberculin Test TB(PPD) *Chest X Ray* *(**only if TB test is positive**)*		

General Appearance

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

Visual Acuity: *Corrected Vision: Yes____ No____* *(Glasses___ Contacts ____ Surgery____)*

OD without correction_____ *OD with correction _____*

OS without correction_____ *OS with correction _____*

List <u>all</u> known Allergies: _____

Physical Activity Restriction recommended? Yes ___ No ___ : _____

*List <u>all</u> current medications prescribed:*_____

History of Surgery/Hospitalization: _____

_____ _____

Physician Signature Date License # and or Clinic Stamp