# SANTA MONICA COLLEGE CONFIDENTIAL MEDICAL HISTORY

NAME _____ (Last / First / Middle) STUDENT ID# _____ SEX ____ BIRTHDATE _____ AGE _____

LOCAL ADDRESS _____ PHONE _____

ARE YOU UNDER MEDICAL TREATMENT? ___ Yes ___ No EXPLAIN: _____

DO YOU HAVE A PHYSICAL CONDITION WHICH REQUIRES SPECIAL ARRANGEMENTS? ___ Yes ___ No APPROXIMATE DATE OF LAST VISIT TO PHYSICIAN _____

EXPLAIN: _____

YOUR DOCTOR'S NAME _____ DOCTOR'S ADDRESS _____ DOCTOR'S PHONE _____

LOCAL PERSON TO NOTIFY IN AN EMERGENCY _____

NAME _____ RELATIONSHIP _____ ADDRESS _____ PHONE _____

SIGNATURE _____ DATE _____

**PERSONAL HISTORY** Have you ever had or do you now have any of the following? (If "yes," explain in #18). **ALL BOXES MUST BE ANSWERED. "YES" ANSWERS MUST BE EXPLAINED. ANY CHANGE IN CHECKED BOXES, REQUIRES RE-EXAM BY YOUR HEALTH CARE PROVIDER.**

| Yes | No | (Check each item) |
|---|---|---|
| | | **1. HEAD** |
| | | a. Major dental problems |
| | | b. Dizziness/Fainting |
| | | c. Encephalitis |
| | | d. Frequent headaches |
| | | e. Head injuries |
| | | f. Migraine |
| | | g. Seizures/Convulsions |
| | | h. Periods of unconsciousness |
| | | **2. EYES** |
| | | a. Allergies |
| | | b. Eye disease or injury |
| | | c. Wear glasses |
| | | d. Wear contact lenses |
| | | **3. EARS/NOSE/THROAT** |
| | | a. Frequent colds |
| | | b. Severe tooth/gum infection |
| | | c. Ear trouble |
| | | d. Hearing problem |
| | | e. Frequent nose bleeds |
| | | f. Sinusitis |
| | | g. Frequent sore throat |
| | | h. Operation |
| | | **4. NECK** |
| | | a. Stiffness |
| | | b. Thyroid trouble |
| | | c. Enlarged glands |
| | | **5. CHEST/HEART/LUNGS/VASCULAR** |
| | | a. Breast disease or masses |
| | | b. Chest pain/pressure/palpitation |
| | | c. Heart disease/murmur |
| | | d. High blood pressure |
| | | e. Rapid or irregular pulse |
| | | f. Varicose veins |
| | | g. Asthma |
| | | h. Chronic cough |
| | | i. Coccidioidomycosis (Valley Fever) |
| | | j. Emphysema |
| | | k. Histoplasmosis |
| | | l. Lung disease |
| | | m. Night sweats |
| | | n. Pneumonia |
| | | o. Tuberculosis |
| | | p. Pleurisy |
| | | q. Wheezing |
| | | r. Shortness of breath |
| | | s. Coughing up blood |
| | | t. Stroke |
| | | u. Are you exposed to any fumes, dusts, or solvents? |

| Yes | No | (Check each item) |
|---|---|---|
| | | **6. GASTRONINTESTINAL** |
| | | a. Abdominal pain |
| | | b. Recent changes in appetite |
| | | c. Recent changes of bowel habits |
| | | d. Recent constipation |
| | | e. Frequent diarrhea |
| | | f. Digestive disorder |
| | | g. Difficulty swallowing |
| | | h. Recurrent vomiting |
| | | i. Gastric or duodenal ulcers |
| | | j. Hemorrhoids/Rectal fistula |
| | | k. Other Ano-rectal disorder |
| | | l. Hepatitis |
| | | m. Hernia |
| | | n. Intestinal worms |
| | | o. Jaundice |
| | | p. Black bowel movements |
| | | q. Vomiting blood |
| | | r. Intestinal inflammation |
| | | s. Gall bladder disease |
| | | **7. GENITOURNINARY** |
| | | a. Blood, albumin, sugar in urine (circle which) |
| | | b. Kidney disease |
| | | c. Kidney stones |
| | | d. Bladder disease |
| | | e. Painful urination |
| | | f. Frequent urination |
| | | g. Sexually transmitted disease |
| | | h. Genital disorders |
| | | i. Prostatic/Testicular disorder |
| | | j. Other |
| | | **FEMALES** |
| | | k. Abnormal PAP smears |
| | | l. Ovarian cysts |
| | | m. Pelvic inflammatory disease |
| | | n. Vaginal discharge/itching |
| | | o. Menstrual pain of irregularity |
| | | p. Number of pregnancies |
| | | q. Number of living children |
| | | r. Other |
| | | **8. MUSCULOSKELETAL/NEUROLOGICAL** |
| | | a. Arthritis or Rheumatism |
| | | b. Vertebrae disc problems |
| | | c. Swollen or painful joints |
| | | d. Bone infections |
| | | e. Amputation |
| | | f. Speech defect |
| | | g. Paralysis, tremor, muscle |
| | | h. Neuralgia, numbness |
| | | i. Back trouble |
| | | j. Injuries |

**9. MENTAL HEALTH (circle each item)**
Frequent nightmares, Trouble concentrating, Cry often, Feeling of depression, Tendency to worry, Memory loss, Mental health disorder, Considerable loneliness, Have used narcotics, tobacco, amphetamines, Cocaine, Stimulants, LSD, or Other Hallucinogens more than once, Use of Alcohol, Marijuana, Tranquilizers, Sleeping pills, Considerable nervousness, Difficulty sleeping, Considered suicide, Lose temper often

**10. BLOOD DISORDER (circle each item)**
Anemia, Any unusual bleeding, Disease or Enlargement of glands/lymph nodes, Sickle Cell disease

**11. CHRONIC DISEASE (circle each item)**
Diabetes, Congenital Problems. Hypertension, Rheumatic fever, Other

**12. ADDITIONAL MEDICAL HISTORY (circle each item)**
Cancer, Operations, Recent gain or loss of weight Serious illness, Sexual problems, Skin disorder/ Infections, STD's, Unusual fatigue, Other

**13. ALLERGIES (circle each item)**
Medications/Drugs, Bee stings, Foods, Hay Fever, Other _____

**14. PAST ILLNESSES (circle each item)**
Measles, Mumps, Rubella, Chicken pox
Other _____

**15. DRUGS RECENTLY TAKEN (circle each item)**
Cortisone, ACTH, Anticoagulants, Tranquilizers, Mood elevators, Anti-convulsants, Hypotensives (high blood pressure medicines), Aspirin

Have you ever received treatment for:
Asthma, Rheumatism, Rheumatic fever

**16. IMMUNIZATION HISTORY (circle and date)**
Tdap: _____

Measles/Mumps/Rubella: 1 _____
2 _____

Hepatitis B:
1 _____ 2 _____ 3 _____
Varicella _____
Flu _____
Other _____

17. LIST SURGERY DATES: _____

18. EXPLAIN ALL "YES" ANSWERS IN ITEMS 1-8 AND ANY CIRCLED ITEMS FROM 9-15: _____

# SANTA MONICA COLLEGE CONFIDENTIAL MEDICAL HISTORY

| Yes | No | |
|---|---|---|
| | | 1. Has anyone in your family (grandmother, mother, father, brother, sister, aunt, uncle) died suddenly before the age of 50 years? |
| | | 2. Have you ever passed out during exercise or stopped exercising because of dizziness? |
| | | 3. Have you had asthma (wheezing), hay fever, or coughing spells after exercise? |
| | | 4. Have you ever broken a bone, had to wear a cast, or had an injury to any joint? |
| | | 5. Have you had a history of a concussion (getting knocked out)? |
| | | 6. Have you ever suffered a heat-related illness (heat stroke)? |
| | | 7. Have you had anything you want to discuss with the physician? |
| | | 8. Have you had a chronic illness or see a physician regularly for any particular problem? |
| | | 9. Are you taking any medicine? (Please name them below) |
| | | 10. Do you have allergies to any medications? (Please name them & state the reaction) |

**Explain any "yes" answers:** _____

_____

_____

## PHYSICAL EXAMINATION (to be performed by Physician)

| | Normal | Abnormal |
|---|---|---|
| **GENERAL:** Posture, gait, speech, appearance | | |
| **HEAD:** Tenderness | | |
| **EYES:** Lids, Sclera, Conjuctiva, Muscles, Cornea, Pupils, Fundi, Peripheral fields | | |
| **EARS:** Pinna, Canal, Drum, Hearing | | |
| **NOSE:** Septum, Obstruction, Mucosa | | |
| **MOUTH/THROAT:** Lips, Tonsils, Breath, Teeth, Tongue, Mucosa, Pharynx | | |
| **NECK:** Thyroid, Motion, Trachea, Veins | | |
| **LYMPHATICS:** Cervical, Axillary, Inguinal, Supraclavicular | | |
| **CHEST/LUNGS:** Symmetry, Percussion, Excursion, Sounds | | |
| **CARDIOVASCULAR:** PMI, Rate, Rhythm, Sounds, Murmurs, Neck Bruits, Upper Ext. Pulses, Lower Ext. Pulses, Leg Veins, Edema, Abd. Bruits | | |
| **BREASTS:** Masses, Discharge, Nipple/Areola, Scar | | |
| **ABDOMEN:** Tenderness, Organs, Hernia, Masses, Sounds | | |
| **MUSCULOSKELETAL:** Back, Upper, Extremities, Lower Extremities | | |
| **SKIN:** Birthmarks, Texture, Other lesions, Color | | |
| **NEUROLOGIC:** Reflexes: Biceps, Triceps, Knee, Ankle, Romberg, Babinski, Cranial N. Sensory, Coordination, Tremor Vibratory | | |
| **MENTAL STATUS:** Orientation, Affect, Judgement, Cognition/ Memory, Abstraction, Hallucination/Delusion | | |

**Ht.** _____ **Wt.** _____ **TPR.** _____

**BP** **R:**_____/_____ **L:**_____/_____

**Vision (uncorrected)** **R: 20/**_____ **L: 20/**_____ **Both: 20/**_____

**(corrected)** **R: 20/**_____ **L: 20/**_____ **Both: 20/**_____

**Plus Sphere:** _____ **Cover** _____ **Color** _____

**Pure tone Audiogram** _____**Pass** _____**Fail**

**1st Step TB Mantoux:**

**Date done** _____ **Date read** _____ **Result** _____

**Chest X-ray date** _____ **Result** _____

**2nd Step TB Mantoux:**

**Date done** _____ **Date read** _____ **Result** ____

**Chest X-ray date** _____ **Result** _____

**OR**

**TB QuantiFERON / T-Spot / IGRA Blood Test (Please circle test run)**

**Date**_____ **Result**_____

****************************ATTACH ALL LAB RESULTS****************************

**DETAILED DESCRIPTION OF ABNORMAL FINDINGS:**

_____

_____

_____

**Student meets Physical Exam Requirements with no limitations: No** ☐

**Student meets Physical Exam Requirements with no limitations: Yes** ☐

**Meets Requirements with Restrictions (explain):**

_____

_____

_____

**Date Examined:** _____

**Print MD/RNP Name:** _____

**MD/RNP Signature:** _____

**Address:** _____

**Phone:** _____

**Please attach business card or professional stamp here**

Updated 10/2018 HS