

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			Fasting Blood Glucose		
Temperature			Urinalysis		
Pulse			Required Vaccinations		
Weight			Varicella (Chickenpox)		
Height			Tetanus (Td/Tdap)		
Mood			MMR		
Recommended Vaccinations			Tuberculin Test TB(PPD)		
<ul style="list-style-type: none"> ✓ Meningitis (Incoming Freshmen) ✓ Hepatitis B Series ✓ HPV 			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 all known Allergies: _____

Physical Activity Restriction recommended? Yes ___ No ___ : _____

List all current medications prescribed: _____

History of Surgery/Hospitalization: _____

Physician Signature

Date

License # and or Clinic Stamp