



HARMONY HEALTH CARE INSTITUTE, INC.

10 Al Paul Lane, Suite 204, Merrimack, NH 03054
603-886-0822, Toll Free: 877-886-0822 • Fax: 603-886-0877

www.harmony-health.org

Health Status Verification / Physical Exam Form

Directions:

- Required of all students
- Please print or type
- Must be submitted 7 days prior to start of class
- The information provided on this form is used strictly for student health status verification and will not be released to anyone without the student's knowledge and consent.
- All students must complete this form and have it signed by a medical provider. Failure to complete this form before the course start date will result in removal from class.

Name:

Date of Birth:

Last

First

Middle

Month / Date / Year

Gender

Race

Religion

Marital Status

Citizenship

Country of Birth

Social Security Number (if available): _____ Home telephone: _____

Home Address: _____

Number and Street

City

State

Zip

Country

Parent or Legal Guardian: _____

Name

Address and telephone if different from above

Who should we contact in case of emergency, if different from above?

Name: _____ Telephone: _____

E-mail Address: _____

Medical History

Allergies

Type (food, medication, other)

Reaction

1. _____

2. _____

3. _____

Medical History / Physical Exam (page 2 of 3)

Current Medications

Name of medication	Dosage	Reason for medication
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Hospitalization and / or Surgery

Date	Description
_____	_____
_____	_____

Medical Illnesses or Problems

Illness or problem	Explanation
<input type="checkbox"/> Heart disease (<i>hypertension, etc.</i>) _____	_____
<input type="checkbox"/> Endocrine problem (<i>thyroid, diabetes, etc.</i>) _____	_____
<input type="checkbox"/> Epilepsy (<i>seizure disorder</i>) _____	_____
<input type="checkbox"/> Chemical dependency (<i>alcoholism, etc.</i>) _____	_____
<input type="checkbox"/> Pulmonary problem (<i>bronchitis, asthma, pneumonia, etc.</i>) _____	_____
<input type="checkbox"/> Eating disorder (<i>anorexia nervosa, bulimarexia</i>) _____	_____
<input type="checkbox"/> Depression / anxiety _____	_____
<input type="checkbox"/> Other _____	_____

Family History

Relative	Age	State of Health	If deceased, cause of death
Father _____	_____	_____	_____
Mother _____	_____	_____	_____
Siblings _____	_____	_____	_____

Has any blood relative (maternal or paternal grandparents, parents, siblings) had any of the following?

	Relationship	Explanation (e.g., heart attack)
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Heart trouble <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Breast cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Seizure disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Substance abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Other <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

Social Habits

Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much per day? _____	For how many years? _____
Do you use alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much per week? _____	_____
Are you on a diet? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type? _____	_____

Mental Health Care (Psychiatric or Psychological)

Date	Problem and type of care given
_____	_____
_____	_____

Other Medical Information

Please note any other pertinent information (e.g., use of eyeglasses, contact lenses, dentures, etc.) that you feel would be essential to Student Health Services to ensure that you receive complete medical care while at HHCI.

I hereby state that to the best of my knowledge, my answers to the above questions are correct.

Student's Signature

Medical Provider's Signature

Date

Medical History / Physical Exam (page 3 of 3)

Note: All items must be completed

Patient's Name: _____

Date of Birth: _____

 Last First Middle Month / Date / Year

 Height Weight BP

Laboratory Finding: These tests are required and must be completed:

Date _____ Vision* _____ Color Vision _____
 Hct. or Hgb. _____ Without glasses: Right 20 / _____ Left 20 / _____
 Urine: Glucose _____ Protein _____ With glasses: Right 20 / _____ Left 20 / _____
 Hearing*: Right _____ Left _____

*may be done by your medical office

Check the proper column for each item Enter "N.E." if not evaluated	Normal	Abnormal	Note: Give details of each abnormality. Enter corresponding number before each comment.
1. Head, neck, face, and scalp			
2. Nose and sinuses			
3. Mouth, teeth, gingiva, and throat			
4. Ears - general (canals, drums, etc.)			
5. Eyes - general (lids, pupils, motions, etc.)			
6. Lungs, chest, and breasts			
7. Heart			
8. Vascular system (include varicosities)			
9. Abdomen and viscera (include hernia)			
10. Ano-rectal and pilonidal			
11. Endocrine system			
12. Genito-urinary system			
13. Upper extremities			
14. Lower extremities			
15. Spine, other musculoskeletal			
16. Skin and lymphatic (include acne)			
17. Neurological system			
18. If female, give menstrual history; specify medication.			

Is student cleared for full participation in all healthcare training activities? Yes No

If no:

Any history of emotional illness or eating disorders? Yes No

Present Yes No

Past Yes No

Are there special medical instructions for HHCI while the student is in school? Yes No

If yes, provide details on reverse or on separate sheet.

Medical Provider Signature _____

Please print or stamp

 Name

 Address

 Telephone



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IMMUNIZATION RECORD FORM

Please type or print clearly.

Name: _____ SS# _____
Last First Middle

Street: _____
Number and Street City State Zip Code

Email: _____ Phone: _____

1. Documentation of Immunity to Chicken Pox, Rubeola (Measles), Mumps and Rubella

Chicken Pox: (Varicella) Two varicella vaccines at least 4 weeks apart or positive serology or history of health provider diagnosed Varicella. (Titre ratio is required for those with only one recorded vaccine.)

Rubeola: Two measles containing vaccines with at least 1 dose after 1980 or positive serology or history of healthcare provider diagnosed measles.

Mumps: Two mumps containing vaccines or positive serology or history of healthcare provider diagnosed mumps.

Rubella: Two rubella containing vaccines or positive serology.

DISEASE*	DATE OF IMMUNIZATION		OR	TITRE RATIO AND DATE	OR	DOCUMENTATION OF DISEASE BY MD OR NP
	1st	2nd				
Chicken Pox			OR		OR	
Rubeola (Regular Measles)						
Mumps						
Rubella						

*Documented history of disease or immunization or titre ratio is required for chicken pox, rubeola, and mumps if born after 1957.

2. Evidence of Absence of Tuberculosis. Please submit documentation of one of the following:

- A negative Mantoux test within the last 12 months.
- If a previous Mantoux was done 12 to 24 months ago, a new test is required. Please provide record of both tests.
- If no previous test has been done, or was done more than 24 months prior, a two Step Mantoux Test is **required**.

Note: Neither pregnancy nor Bacille Calmette-Guerin (BCG) vaccine are considered exclusions for tuberculin skin test requirement.

	Date Administered	Date Read	Results	Read By
(within 12 months)				
(2 nd step if required)				
(12 -24 months ago)				

A positive Mantoux test requires a clear chest X-ray within the last 5 years and an evaluation by a physician to certify that you do not have communicable TB within the last 12 months.

Chest X-ray date: _____ Results: _____

3. Evidence of Hepatitis B Immunization (3 dose series: 1st month, 2nd month, 6th month)

Step #1 Date: _____	Step #2 Date: _____	Step #3 Date: _____
Previous immunization without documentation requires titre. Titre recommended after completion of series		
Titre Date: _____		Results: _____

4. Evidence of Tetanus/Diphtheria Immunization Within Last 10 Years.

Date of Immunization: _____

I understand that HHCI will share this information with appropriate faculty, clinical agencies or in the event of an emergency.

Signature of Physician/Nurse Practitioner completing form

Date