Harmony Health Care Institute, Inc

10 Al Paul Lane, Suite 204, Merrimack, NH 03054
603-886-0822, Fax: 603-886-0877
www.harmony-health.org

Health Status Verification / Physical Exam Form

Directions:

- Required of all students
- Please print or type
- 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.

Name:

_____ _____
Last First Middle Date of Birth (Month/Day/Year)

_____ _____ _____ _____ _____ _____
Gender Race Religion Marital Status Citizenship Country of Birth

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

Home Address: _____

_____
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. _____

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Hospitalization and/or Surgery

Date Description

_____
_____
_____

Medical Illnesses or Problems

Illness or problem **Explanation**

□ Heart disease (*hypertension, etc.*) _____
□ Endocrine problem (*thyroid, diabetes, etc.*) _____
□ Epilepsy (*seizure disorder*) _____
□ Chemical dependency (*alcoholism, etc.*) _____
□ Pulmonary problem (*bronchitis, asthma, pneumonia, etc.*) _____
□ Eating disorder (*anorexia nervosa, bulimarexia*) _____
□ Depression / anxiety _____
□ 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) has any of the following?

Disease	Yes/No	Relationship	Explanation (e.g. heart attack)
Diabetes	☐Yes ☐No		
Heart Trouble	☐Yes ☐No		
Breast Cancer	☐Yes ☐No		
Cancer	☐Yes ☐No		
Seizure disorder	☐Yes ☐No		
Substance abuse	☐Yes ☐No		
Other	☐Yes ☐No		

Social Habits

Do you smoke? ☐Yes ☐No If yes, how much per day? _____ For how many years? _____
Do you use alcohol? ☐Yes ☐No If yes, how much per week? _____
Are you on a diet? ☐Yes ☐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**

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Medical History / Physical Exam *(page 3 of 3)*
Note: All items must be completed.

Patient's Name:

_____ _____
Last First Middle Date of Birth (Month/Date/Year)

_____ _____ _____
Height Weight BP

Laboratory Finding: These tests are required and must be completed: *May be done by your medical office

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 _____

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, gingival, 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 of this form or on separate sheet.

_____
Medical Provider Name & Signature *(please print or stamp)*

Date of Last Physical Exam: _____

_____
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			TITRE RATIO AND DATE		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)				
(2nd 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 or Tdap 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.

_____

Name & Signature of Physician/Nurse Practitioner Completing Form *(please print or stamp)* **Date**