



# **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



# 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](http://www.harmony-health.org)

## 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 after 12 months of age with at least 1 dose after 1980 or positive serology or history of healthcare provider diagnosed measles.

**Mumps:** 1 mumps containing vaccine after 12 months of age or positive serology or history of healthcare provider diagnosed mumps.

**Rubella:** 1 rubella containing vaccine after 12 months of age or positive serology.

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

\*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.** A two Step Mantoux Test is **required** if you have not had a Mantoux test for TB in the last 12 months. A one Step Mantoux test is sufficient if Mantoux testing has been done in the last 12 months. Please submit both results. ie. Results 1: within past 12 months. Results 2: within 12-24 months. Neither pregnancy nor Bacille Calmette-Guerin (BCG) vaccine are considered exclusions for tuberculin skin test requirement.

Two Step Mantoux Test:	Date Administered	Date Read	Results	Read By
(within 12 months) <b>Step 1</b>				
(within 12 months) <b>Step 2</b>				
<b>Previous Test</b> (within 12-24 months)				

A positive Mantoux test requires a chest X-ray or an evaluation by a physician to certify that you do not have communicable TB.  
 Chest X-ray date: \_\_\_\_\_ Results: \_\_\_\_\_

**3. Evidence of Hepatitis B Immunization (3 dose series: 1<sup>st</sup> month, 2<sup>nd</sup> month, 6<sup>th</sup> 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 \_\_\_\_\_