ALLEGANY COLLEGE of MARYLAND
NURSE MANAGED WELLNESS CLINIC

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HEALTH CAREERS MEDICAL HEALTH EXAMINATIONS RECORD
CONFIDENTIAL
STUDENT HEALTH PROFILE

PART I: TO BE COMPLETED BY STUDENT

Name (Last, First, MI)	DOB	Gender ID ❑ M ❑ F ❑ Other
Address (include city, state and zip)	Telephone (area code & number) Student ID#	
Emergency Contact	Telephone Number	Relationship
Personal Physician (include address)		Telephone
Program Applying To:		

PART II: STUDENT PERSONAL HEALTH HISTORY *(STUDENT – Please PRINT and fill out completely in INK)*

PERSONAL HEALTH HISTORY: Check below all of the following which have applied either NOW OR IN THE PAST. Please check each item. If yes, please explain below (if additional space is needed, please attach separate sheet of paper).

Yes	No		Yes	No	
❑	❑	Chicken Pox	❑	❑	Heart disease
❑	❑	Measles	❑	❑	Heart murmur
❑	❑	Mononucleosis	❑	❑	Asthma
❑	❑	Typhoid fever	❑	❑	Hay fever
❑	❑	Kidney disease	❑	❑	Back problems
❑	❑	Diabetes	❑	❑	Orthopedic problems
❑	❑	Poliomyelitis	❑	❑	Cancer
❑	❑	Rheumatic fever	❑	❑	Ulcer
❑	❑	Tuberculosis	❑	❑	Arthritis
❑	❑	Hypoglycemia	❑	❑	Epilepsy or convulsions
❑	❑	Jaundice	❑	❑	Chronic bronchitis
❑	❑	Hepatitis	❑	❑	Migraine headaches
❑	❑	Frequent sore throats	❑	❑	Skin disease
❑	❑	Ear infections	❑	❑	Sexually transmitted diseases
❑	❑	Hearing problems			
❑	❑	Visual problems	❑	❑	Surgeries
❑	❑	Thyroid dysfunctions	❑	❑	Hospitalization
❑	❑	Bleeding tendency			
❑	❑	Chest pain			
❑	❑	Shortness of breath			
❑	❑	High blood pressure			

If yes, please explain: _____

FAMILY MEDICAL HISTORY:

_____

CHECK EACH ITEM BELOW YES OR NO.
ANY ITEMS CHECKED YES MUST BE EXPLAINED BELOW.

Yes	No	
❑	❑	Allergies (include all known drug allergies)
❑	❑	Sensitivity to chemicals, dust, latex, etc.
❑	❑	Inability to perform certain motions.
❑	❑	Physical work limitations
❑	❑	Are you currently taking any medication, including Over the counter medications? Please list all:
❑	❑	Are you currently using any substance (tobacco, alcohol, or any other drugs)?

I hereby grant the Nurse Management Wellness Clinic permission to share medical healthcare records with the health profession programs and clinical agencies as required by the program of study.

I hereby acknowledge that the information on the Student Personal Health History form is true and complete to the best of my knowledge and nothing has been omitted which would interfere with academic and technical standards that are essential to the educational purpose or objective of a program or class.

STUDENT SIGNATURE: ✗_____ **DATE:** _____

Student Name:_____

PART III: To Be Completed by Physician

Weight	Height w/o shoes	Temp	Pulse	Resp	BP

Vision Left:_____ Right:_____Both:_____	❑ Not Corrected ❑ Corrected: _____

Describe every abnormality in detail in Part V of form.

Check each item in appropriate column--enter NE if not examined	Normal Findings	Abnormal Findings	Deferred Findings	Comments
Skin				
Eyes				
Ears				
Nose				
Mouth/Teeth/Throat				
Neck				
Breast Examination				
Lungs and Thorax				
Heart				
Abdomen				
Back				
Extremities				
Genitalia				
Neurological				

Depression Screening

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

NOTE: If the patient has a positive response to either question, consider administering the Patient Health Quesitonaire-9 or asking the patient more questions about possible depression. PHQ-2 score ≥ 3 is suggestive of elevated symptoms of depression warranting additional screening or follow-up. Adapted from patient health questionnaire (PHQ) screeners. http://www.phqscreeners.com. Accessed August 2019.

Student must be free of contagion or of any conditions which may endanger the health and well-being of other students or patients and possess sufficient physical stamina with or without reasonable accommodations to fulfill the requirements of the program and the customary requirements of the profession.

Are there any abnormal findings on evaluation for concern? ❑ YES** ❑ NO ****(If YES, please explain)**

_____

_____

_____

_____

_____

Printed Name of Physician, Nurse Practitioner, or Physician Assistant_____

Signature of Physician, Nurse Practitioner, or Physician Assistant_____ **Date** _____

Address_____

City/State/Zip _____ **Telephone**_____