

**WAYNE STATE UNIVERSITY**  
SCHOOL OF MEDICINE

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Initial

Local Address: \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code: \_\_\_\_\_

Local Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Person to be notified in emergency: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ (HOME)  
 \_\_\_\_\_ (WORK)

Sex: M \_\_\_ F \_\_\_ Year of Expected Graduation: \_\_\_\_\_ (CELL)

**FAMILY HISTORY:**

Has any blood relative had (parent, brother, sister)

Check Each Item Yes No Relationship

**REQUIRED TITERS AND IMMUNIZATIONS:**

Immunizations Date/Year Completed Booster/Titer

Check Each Item	Yes	No	Relationship	Immunizations	Date/Year Completed	Booster/Titer
Tuberculosis				Diphtheria		
Diabetes				Tetanus		
Convulsions or Seizures				Polio		
Cancer				Measles		
Asthma				Mumps		
Emotional Problems				Rubella		
Hypertension				Varicella (1 <sup>st</sup> , 2 <sup>nd</sup> )		
Heart Disease				Hepatitis A (1 <sup>st</sup> , 2 <sup>nd</sup> )		
Alcohol/Drug Problem				Hepatitis B (1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> )		
				Hepatitis C (titer)		
				Tuberculin Test		Positive Negative
				Blood Type	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> Positive <input type="checkbox"/> Negative	

Have you ever had or have you now any of the following:

	Yes	No		Yes	No
Rheumatic Fever, Inflammatory Rheumatism or Heart Disease			Severe Headaches or Lapses of Consciousness		
Palpitation or Chest Pain			Fainting or Dizzy Spells		
Shortness of Breath			Epilepsy, Convulsions or Seizures		
Chronic Cough			Emotional Problems		
Tuberculosis			Ulcers or Stomach Pain		
Sugar or Albumin in Urine			Backache, Painful Joints or Back Pain		
Kidney Disease			Diabetes		
Asthma or Wheezing *requiring treatment			Hypertension		
Eye or Ear Trouble			Allergies <input type="checkbox"/> NKA <input type="checkbox"/> Latex		
Eating Disorder			Liver Disease		

Do you wear a medical alert ID?  No  Yes If yes, for what reason? \_\_\_\_\_

List significant injuries or operations which you have had: \_\_\_\_\_ If none, check here \_\_\_\_\_

Injury or Operation/Date(s)	Hospitalizations/Date(s)

# Medical Examination

**Confidential To The Doctor:** The reverse side of the sheet should have been completed by the student prior to your examination. Please review the history for completeness and verify it in so far as you are able.

We would appreciate your advice regarding any special health consideration for this student.

*This examination is at student expense.*

Age \_\_\_\_\_ Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ B. P. \_\_\_\_\_ Pulse \_\_\_\_\_

Build: Slender \_\_\_\_\_ Med. \_\_\_\_\_ Hvy. \_\_\_\_\_ Obese \_\_\_\_\_ Posture \_\_\_\_\_

**E.E.N.T.** Vision O.S. \_\_\_\_\_ O.D. \_\_\_\_\_ Glasses Yes \_\_\_ No \_\_\_  
Ears and Hearing \_\_\_\_\_ Rt. \_\_\_\_\_ Lt. \_\_\_\_\_  
Nose \_\_\_\_\_ Mouth \_\_\_\_\_ Throat \_\_\_\_\_  
Teeth \_\_\_\_\_ Thyroid \_\_\_\_\_

**CHEST** Deformity \_\_\_\_\_ Expansion \_\_\_\_\_ Breasts \_\_\_\_\_  
Lungs \_\_\_\_\_ Rhythm \_\_\_\_\_ Enlarged? \_\_\_\_\_  
Heart: Rate \_\_\_\_\_

**ABDOMEN & G.U.** Inspection & Palpation \_\_\_\_\_  
Hernia \_\_\_\_\_ Scars \_\_\_\_\_  
Genitalia \_\_\_\_\_

**EXTREMITIES & SPINE** Upper Limbs \_\_\_\_\_  
Lower Limbs \_\_\_\_\_

**MENSES** Regular \_\_\_\_\_ Age of Onset \_\_\_\_\_  
Dysmenorrhea \_\_\_\_\_  
Amenorrhea \_\_\_\_\_

## IMMUNIZATIONS GIVEN:

Hepatitis A (dates) \_\_\_\_\_ Tetanus (date) \_\_\_\_\_ Varicella \_\_\_\_\_  
Hepatitis B (dates) \_\_\_\_\_ Measles \_\_\_\_\_ Rubella \_\_\_\_\_  
Hepatitis C (dates) \_\_\_\_\_ Mumps \_\_\_\_\_ Diphtheria \_\_\_\_\_

Any Allergies or Sensitivities ? \_\_\_\_\_

Please note any emotional or physical condition (past or present) \_\_\_\_\_

Any present medical treatment ? \_\_\_\_\_

Previous Tuberculin Test: Result \_\_\_\_\_ Date \_\_\_\_\_ Chest X Ray \_\_\_\_\_

Any Physical limitations or restrictions ? \_\_\_\_\_

Comments or Recommendations: \_\_\_\_\_

**Please Sign and date** \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone# \_\_\_\_\_

Email Address \_\_\_\_\_