College Health Service

Health Science Physical Form

Report _____
Received _____
Approved _____

This side to be completed by student

NAME _____ **HVCC ID:** _____
LOCAL ADDRESS _____ **DATE OF BIRTH** _____
LOCAL PHONE _____ **CURRICULUM** _____
PARENT OR GUARDIAN _____ **FAMILY PHYSICIAN** _____
ADDRESS _____ **ADDRESS** _____

TELEPHONE _____ **TELEPHONE** _____
EMERGENCY NUMBER FOR DAYS _____
Name ***Telephone Number***

PERSONAL HISTORY

If you **ever** have had or now have any of the following, check yes, if not please check no.

	YES	NO		YES	NO
Epilepsy	☐	☐	Wear Glasses/Contact Lenses	☐	☐
Diabetes	☐	☐	Ear Trouble	☐	☐
High Blood Pressure	☐	☐	Heart Problems	☐	☐
Eating Disorder	☐	☐	Pain or Pressure in Chest	☐	☐
Measles	☐	☐	Palpitations or Pounding of Heart	☐	☐
German Measles	☐	☐	Cancer	☐	☐
Mumps	☐	☐	Frequent Indigestion	☐	☐
Chicken Pox	☐	☐	Sugar or Albumin in Urine	☐	☐
Scarlet Fever	☐	☐	Insomnia	☐	☐
Whooping Cough	☐	☐	Nervousness, Tension, Anxiety	☐	☐
Rheumatic Fever	☐	☐	Excessive Worry	☐	☐
Asthma	☐	☐	Depression	☐	☐
Hay Fever	☐	☐	Backache	☐	☐
Chronic Cough	☐	☐	Skin Disease	☐	☐
Frequent Colds	☐	☐	Trick or Locked Knee	☐	☐
Frequent Sore Throats	☐	☐	Current or Previous Occupational exposure		
Bronchitis or Pneumonia	☐	☐	to ionizing radiation. (If yes, have		
Infectious Hepatitis	☐	☐	current or past employer or		
Infectious Mononucleosis	☐	☐	monitoring company submit		
Tuberculosis or Contact with Tuberculosis	☐	☐	current cumulative dose.)	☐	☐
Eye Trouble	☐	☐			

Give details of those checked **YES** and approximate dates (if necessary, use additional sheet) _____

Are you under the care of a physician? ☐ **YES** ☐ **NO**
Have you ever been hospitalized? ☐ **YES** ☐ **NO**
If yes, indicate where and for what reason _____
Do you have ay mental or physical disability which would impair your ability to complete your chosen program?
☐ **YES** ☐ **NO**

Allergies _____ **Food** _____
*** IMPORTANT - ALLERGIES TO DRUGS OR MEDICATIONS?** _____

Are you presently taking medications? ☐ **YES** ☐ **NO** If so, state what and for what condition _____

INFORMATION ON THIS FORM MAY BE SHARED WITH YOUR DEPARTMENT CHAIRPERSON AT THE DISCRETION OF THE COORDINATOR OF HEALTH SERVICES.

Please return this form to:
Hudson Valley Community College, College Health Service, 80 Vandenburgh Avenue, Troy, NY 12180

(This side to be completed by examining physician)

Height _____ **Build** _____ **Blood Pressure** _____

Weight _____ **Pulse** _____ **Hearing: Right** _____

Left _____

Vision: Right 20/ _____ **Corrected to 20/** _____ **by contacts** _____

Left 20/ _____ **Corrected to 20/** _____ **by glasses** _____

CLINICAL EVALUATION

Check each item in proper column	**NORMAL**	**ABNORMAL**	**GIVE DETAILS OF EACH ABNORMALITY & IDENTIFY BY NO.**
1. Head, Neck, Face and Scalp			
2. Nose and Sinuses			
3. Throat			
4. Oral Cavity			
5. Ears *(perforation or drum, etc.)*			
6. Eyes *(lids, conjunctiva, color blindness, etc.)*			
7. Pupils and ocular motion			
8. Lungs, chest, and breasts			
9. Heart *(include estimate of cardiac function)*			
10. Vascular system *(varicosities, etc.)*			
11. Abdomen and viscera *(include hernia/other disorders)*			
12. Ano-rectal *(pilonidal cyst)*			
13. Endocrine system			
14. G-U system			
15. Upper extremities *(strength/movement)*			
16. Feet			
17. Lower extremities *(as for uppers)*			
18. Spine, other musculo-skeletal			
19. Skin and lymphatics			
20. Neurologic			
21. Psychiatric			

*** IS THIS STUDENT PHYSICALLY ABLE TO PARTICIPATE IN UNLIMITED PHYSICAL ACTIVITY INCLUDING INTERCOLLEGIATE ATHLETIC PROGRAM AND/OR AN ROTC PROGRAM?**
YES ___ NO ___

If no, please cite reasons.

_____

Summary and additional comments.

_____

_____

_____

ALL THESE REQUIREMENTS MUST BE MET BEFORE ENROLLMENT
SEE ATTACHED SHEET FOR SUPPLEMENTAL TESTS AND IMMUNIZATION REQUIREMENTS.

_____ _____

Type or Print Name of Examining Physician *Signature of Examining Physician*

Practice stamp required

ADDRESS: _____

_____

_____

PHONE: _____

LICENSE NO.: _____

DATE: _____

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