**THE UNIVERSITY OF TENNESSEE AT CHATTANOOGA**
**PHYSICAL THERAPY DEPARTMENT**
**MEDICAL HISTORY AND PHYSICAL EXAMINATION**

Instructions for the student: A medical history and physical examination is required prior to entry into the physical therapy program. This service is available through the UTC Student Health Office upon appointment. Immunizations must be completed and/or updated as necessary. Tuberculin skin tests must be updated at least annually. Some clinical sites will require more frequently. The student MUST provide all the information requested on this side of the form. The medical examiner MUST complete the reverse side. It is the responsibility of the student to return the completed form to the department.

STUDENT (print)

Social Security Number ______________________________ Date ________________________

Name ____________________________________________ Date of Birth ______________

Permanent Home address ____________________________________________________

_________________________________________________ Phone ____________________

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Address while in school ______________________________________________________

_________________________________________________ Phone ____________________

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Please check whether or not you have or have had any of the following on the list below:

Condition Yes No Describe

Allergy ___________________________________________________________________

Chickenpox or vaccine _______________________________________________________

Emotional Disorders ________________________________________________________

Hearing Impairments ________________________________________________________

Heart Trouble _____________________________________________________________

Migraine _________________________________________________________________

Peptic Ulcer _______________________________________________________________

Physical Limitations ________________________________________________________

Rheumatic Fever __________________________________________________________

Tuberculosis ______________________________________________________________

Other (Please list) __________________________________________________________

List reasonable accommodations desired __________________________________________

**DO NOT WRITE BELOW THIS LINE**

Cleared for Clinical Yes__No__Date____________Approval___________________________

Student Name______________

## IMMUNIZATIONS & TB SKIN TEST

**Tetanus toxoid** immunization is required every ten years. Date of last booster:____________

**Rubella titer** ______ Date ______ MMR vaccine (if no evidence of immunity) _______(Date)

**VZI titer** ____________________ Vaccines required if not immune______________(Dates)

**Hepatitis B vaccine** -3 injections (Dates) 1) __________ 2) __________ 3) __________

**PPD Tuberculin skin test** (yearly) Date______ Results_______ Date________ Results______

Date______ Results_______ Date________ Results______

Chest x-ray if indicated Date______ Results_______

## LABORATORY

Hct ______ HgB _______ Urinalysis: Alb. ______ Sugar ________ Sp.Gr. ______

## PHYSICAL EXAMINATION

Height ________ Weight ______ B.P. _____ Pulse _______

Vision (Snellen) R20/______ Corrected 20/_______

L20/______ Corrected 20/_______

Please examine this student considering that the student will be working with hospitalized patients as well as with families and groups in the community. Indicate any abnormal findings.

HEENT ______________________________________________________________

Cardiac ______________________________________________________________

Pulmonary ____________________________________________________________

Breast _______________________________________________________________

Abdomen _____________________________________________________________

GU __________________________________________________________________

Pap smear ____________________ (recommended if appropriate, but not required)

Musculoskeletal _______________________________________________________

Neurological __________________________________________________________

Does this student require any follow-up health supervision? Yes _____ No ______

Does this student have a limitation which requires reasonable accommodations? Yes ___ No ___

If yes, please list: _____________________________________________________

**Examiner Name (Printed)** ____________________________________________

**Address of Examiner** ________________________________________________

**Examiner signature** ________________________________ **Date**_______