

**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 _____

Address while in school _____

_____ Phone _____

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

Condition	Yes	No	Describe
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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 Status _____ (Required if you have not had chickenpox or vaccine)

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? _____

Does this student have a limitation which requires reasonable accommodations? _____

If yes, please list: _____

Examiner Name (Printed) _____

Address of Examiner _____

Examiner signature _____ **Date** _____