History and Medical Examination
(CONFIDENTIAL)

Full Name: ______________________________ Date of Birth: Month _______ Day _______ Year _______

APPLICANT: Please complete the first two pages of the medical history and take it to your physician at the time of examination.
PHYSICIAN: Please review this form during examination and indicate the current status of each history problem in section V. below.

MEDICAL HISTORY

I. Has any blood relative had any of the following?

Yes	No		Relation	Yes	No		Relation	Yes	No	Relation
		High blood pressure				Allergies				tuberculosis
		Heart disease				Diabetes				Kidney trouble
		Epilepsy				Migraine headaches				Committed suicide
		Asthma				Cancer (list type)				

II. What is your blood type? __________________ * see lab requirements if unknown

III. Have you ever had or do you now have any of the following?

Yes	No		Yes	No	
		Heart disease			Hepatitis
		Heart murmur			Kidney stone or infection
		High or low blood pressure			Cancer
		Stroke			Glaucoma
		Chest pain			Gout
		Irregular heartbeat			Deformity
		Rheumatic fever			Allergy to any medication
		Asthma			Anorexia
		Tuberculosis			Bulimia
		Thyroid disorder			Hospitalization
		Diabetes			Surgery
		Gall bladder disease			Abortion/miscarriage
		Ulcer			Tested positive for HIV
		Colitis			Treatment for alcohol or drug abuse
		Cirrhosis of the liver			Emotional/psychological problem

IV. Identify each problem listed above, describing the nature and severity of the condition. Include frequency, treatment, medication, surgery, results, onset year and recovery year.

V. Examining Physician's description of current status of any items marked "yes" in section III. And VI.

VI. In the last year have you had or do you now have any of the following?

Head/Neck:	Yes	No		Yes	No		Yes	No				
			Frequent headaches			Head injury			Neck pain			
Eyes:	Yes	No								Yes	No	
			Pain			Infection			Inflammation			Double vision
			Need for glasses									
Ears:	Yes	No		Yes	No		Yes	No		Yes	No	
			Loss of hearing			Ringing in ears			Discharge			
Nose/Throat/Mouth:	Yes	No		Yes	No		Yes	No		Yes	No	
			Loss of smell			Frequency sore throats			Frequent colds			Nosebleeds
			Hay fever			Difficulty swallowing			TMJ			
Heart/Lungs:	Yes	No		Yes	No		Yes	No		Yes	No	
			Wheezing			Persistent cough			Bloody sputum			Varicose veins
			Shortness of breath			Palpitations			Swollen ankles			
			Anemia			Difficulty breathing lying down						
Gastrointestinal:	Yes	No		Yes	No		Yes	No		Yes	No	
			Change in appetite			Indigestion			Vomiting			Diarrhea
			Constipation			Hemorrhoids			Rectal bleeding			Tarry stools
			Abdominal pain									
Urinary:	Yes	No		Yes	No		Yes	No		Yes	No	
			Inability to hold urine			Frequent urination at night			Weak urine stream			Frequent urination in day
			Blood in urine			Pain or burning			Need to urinate without much urine			
Genital/Breasts (women):	Yes	No		Yes	No		Yes	No		Yes	No	
			Painful periods			Menstrual disorder			Breast pain			Lumps
			Breast discharge						Pregnancy			
Genital (men):	Yes	No		Yes	No		Yes	No		Yes	No	
						Prostate trouble						
Endocrine (glands)	Yes	No		Yes	No		Yes	No		Yes	No	
			Swollen glands			Weight change			Night sweats			Tire easily
			Hypoglycemia									
Muscles/Joints:	Yes	No		Yes	No		Yes	No				
			Back pain			Swollen joints			Stiff or painful muscles or joints			
Skin:	Yes	No		Yes	No		Yes	No				
			Rash			Change in mole			Slow wound healing			
Neurological:	Yes	No		Yes	No		Yes	No				
			Dizziness			Fainting			Memory loss			
			Poor coordination			Weakness of extremity						
Psychological:	Yes	No		Yes	No		Yes	No				
			Nervousness			Insomnia			Depression			

VII. Identify each “Yes” item listed above, describing the nature and severity of the condition.
Include frequency, treatment, medication, surgery, results, onset year and recovery year.

Item	Onset year	Recovery year

MEDICAL EXAMINATION

Date of exam _____/_____/_____

The purpose of this examination is to determine if this person is physically suited for studying at Messiah College.

Ht:_____ft_____ Circle one: underweight overweight BP: _____/_____

Wt:_____lbs. Appropriate weight obese Pulse at rest _____

Any arrhythmia? _____

Please examine and check (✓) each area.

	Normal	Abnormal	Describe abnormality in detail
Ears			
Eyes			
Nose			
Throat			
Neck			
Breasts			
Heart			
Lungs			
Abdomen			
Extremities			
Spine			
Glands			

LABORATORY REQUIREMENTS:

PLEASE ATTACH A COPY OF EACH LABORATORY TEST RESULT.
THIS EXAM IS NOT COMPLETE WITHOUT THESE TEST RESULTS.

1. **Complete Blood Count** (include blood type)
2. **Chest x-ray**
3. **Urinalysis**

Physician's comments on any abnormal laboratory results and recommendations for treatment:

____

____

____

____

____

Additional comments:

(Indicate any thoughts that may bear upon this applicant's suitability for college.)

____

____

____

____

____

CONCLUDING STATEMENT

(Please respond to all three statements.)

I have reviewed the medical history and completed a thorough examination and conclude:

1. The applicant is:
   - ☐ in excellent health
   - ☐ in good health
   - ☐ in poor health
2. I have:
   - ☐ no reservations regarding this applicant
   - ☐ reservations and would recommend the following ____

   ____

   ____

Signature of examining Physician______________________ Physician's name, address and telephone number (typed or printed)

____

____

____

____

____