|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** |  | **Yes** | **No** |
| Cough |  |  | Sore Throats |  |  |
| Fevers |  |  | Skin Infections |  |  |
| Night Sweats |  |  | Rash |  |  |
| Weight Loss |  |  | Nausea |  |  |
| Shortness of Breath |  |  | Vomiting |  |  |
| Hemoptysis |  |  | Diarrhea |  |  |

|  |
| --- |
|  |
| **SCHOOL OF MEDICINE HEALTH FORM FOR CLINICAL PLACEMENT** |
|  C:\Users\DR VISHAL\Pictures\logo.JPG **HEALTH FORM FOR CLINICAL PLACEMENT****PART I - HEALTH HISTORY (**Complete this part before going to your physician for an examination)Name (Print) Last First MiddleDate of Birth Social Security No. Male Female Home Telephone No. E-Mail Address: Home Address Number StreetCity/Town State/Country Zip CodePerson to be notified in case of emergency:Name Relationship Home Telephone No. Business Telephone No. Address Number StreetCity/Town State/ Country Zip Code **Please indicate if you have had any of the following in the past 12 months:** **If yes to any of the above, please explain details and current status**1 |

**PART I - HEALTH HISTORY (continued)**

**Name**

Last First Middle

### Answer Yes or No. If the answer to any question below is yes, provide names and addresses of all physicians or healthcare providers who participated in the diagnosis, referral or treatment. Give details, reasons, and dates as appropriate. Please use additional space below or additional pages, if necessary.

1. Has your physical activity been restricted or your education interrupted for medical, surgical or psychiatric

reasons during the past three years? Yes\_

No

1. Do you have any physical disabilities or handicaps?
2. Have you ever received treatment or counseling for a psychiatric condition, personality, character disorder or emotional problem?

Yes No

1. Have you had any illness or injury which required treatment or hospitalization by a physician or surgeon?

Yes No

1. List any medications you are taking regularly
2. Do you use drugs or substances that alter behavior?

G List any allergies and reaction

H. Do you have any significant problems with your health at the present time? No Yes

# I declare that I have had no injury, illness or health condition other than specifically noted above and will notify Windsor University School of Medicine of any changes in my health status.

**Date:**

**Signature:**

**PART II - PHYSICAL EXAMINATION**

NAME

Last First Middle

**To the Examining Physician:**

Please review the student’s Health History Form and complete applicable parts of the examination form. Please comment on all positive answers using the back of this page or additional pages.

Height Weight Blood Pressure Pulse

Describe any abnormalities of the following systems in the space below:

|  |  |
| --- | --- |
| Eyes |  |
| ENT |  |
| Neck |  |
| Lungs |  |
| Heart |  |
| Breast |  |
| Abdomen |  |
| Rectum |  |
| Nervous System |  |
| Genitalia |  |
| Extremities |  |

I have determined that is free from any health impairment which is of potential risk to patients or which might interfere with the performance of his/her duties. This includes the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances that may alter the individual’s behavior.

Date Signature of Examining Physician

Country or State License #

Physician’s Name (Please Print)

Address:

City: State/Country: Zip Code: