



TEXAS COLLEGE MEDICAL EXAMINATION FORM

All Information kept Confidential



Name: _____

Address: _____
Last First Middle
City: ST: Zip:

Telephone: (____) _____ Date of Birth: _____ Gender: M/F (Please Circle)

Name of person case of emergency: _____ Relationship to you: _____

Telephone: (____) _____

I. Record of illness: (Check those that occurred within the past five (5) years).

| | | |
|----------------------|-----------------------|----------------------|
| Frequent Colds _____ | Allergies _____ | Bone Disease _____ |
| Influenza _____ | Chickenpox _____ | Skin Disease _____ |
| Bronchitis _____ | Hernia _____ | Diabetes _____ |
| Pneumonia _____ | Cholera _____ | Kidney Disease _____ |
| Tuberculosis _____ | Rheumatic Fever _____ | Other _____ |
| Asthma _____ | Specify: _____ | |

II. Have you had any of the following to occur? (Check those that occurred within the past five (5) years).

| | | |
|---------------------------|----------------------------|-----------------------|
| Blurred Vision _____ | Leg Pains _____ | Vomiting _____ |
| Recurring Headaches _____ | Palpitation _____ | Sore Throat _____ |
| Blackouts _____ | Respiratory Problems _____ | Abdominal Pains _____ |
| Fainting Spells _____ | Frequent Urination _____ | Constipation _____ |
| Painful Joints _____ | Problems Urinating _____ | Nosebleed _____ |
| Backaches _____ | Cough (prolonged) _____ | Hepatitis _____ |

III. Physical Examination (Must See A License Physician To Complete This Section):

| <u>AREA</u> | <u>COMMENTS</u> | <u>AREA</u> | <u>COMMENTS</u> |
|---------------------------|-----------------|--------------------|-----------------|
| Skin: _____ | _____ | Lymph Glands _____ | _____ |
| Eyes: _____ | _____ | Chest: _____ | _____ |
| Nasopharynx: _____ | _____ | Lungs: _____ | _____ |
| Tonsils: _____ | _____ | Heart: _____ | _____ |
| Thyroid: _____ | _____ | Genitalia: _____ | _____ |
| Blood Pressure: _____ | _____ | Pulse: _____ | _____ |
| Urine (Albumin): _____ | _____ | Microscope: _____ | _____ |
| (Specific Gravity): _____ | _____ | Diabetes: _____ | _____ |
| Hemoglobin: _____ | _____ | Allergies: _____ | _____ |

Immunization for Bacterial Meningitis: _____ (High Importance)

Mental or Emotional Disorders: _____

Recommendations: _____

I hereby certified that this student has been examined by me and is mentally and physically able to enroll in this school.

Examining Physician's Signature

Telephone

Date

Physical Address

City/St

Zip