



TO THE EXAMINING PROVIDER: Please review the student's history and complete this form. Please comment on all affirmative answers. **THIS STUDENT HAS BEEN ACCEPTED.** The information supplied will not affect his/her status. It will be used only as a background for providing health care. This information will not be released without student consent.

PERSONAL MEDICAL HISTORY

MEDICAL HISTORY

To be completed by the Student

Do you have, or have you ever had, any of the following medical conditions?

Yes No

- Absence/damage to any paired organ (kidney, eye, etc.)
- Alcohol or drug use, problem or treatment
- Anxiety or nervousness
- Anaphylaxis or severe allergic reaction
Specify _____
- Anemia
- Arthritis
- Asthma
- Bipolar disorder/manic depression
- Blood disorders or Bleeding trait
- Breast disease
- Cancer or malignancy
- Chronic inflammatory bowel disease
- Chronic kidney condition
- Depression
- Diabetes Mellitus
- Digestive trouble
- Dizziness/fainting
- Ear infections/hearing problems
- Eating disorders: bulimia/anorexia nervosa
- Emotional/mental illness
- Hepatitis B
- Hepatitis C
- Heart Disease
- High cholesterol
- HIV/AIDS (optional response)
- Insomnia/sleep problems
- Kidney disease (congenital or other)
- Migraine/recurrent headaches
- Orthopedic problems/injuries
- Seizure disorder (epilepsy)
- Thyroid disorder
- Tuberculosis

Have you had any surgery? Yes No
Explain: _____

Have you been hospitalized? Yes No
Explain: _____

Other medical conditions not listed above:

CURRENT MEDICATIONS (frequent or regular)

Please list:

No Medication

Allergies

Check the appropriate box(s), if any, of the following allergies:

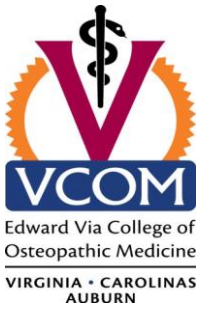
Yes No

- Medications
Specify _____
- Latex
- Food:
Specify _____
- Other:
Specify _____

Student Name: _____

Student Signature: _____

Date: _____



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PHYSICAL EXAMINATION

M F

Student Last Name (Print) First Name Middle

Physical Exam:

	Normal	Abnormal	If Abnormal, please explain
HEENT			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary (inc. hernia)			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			

Do you have any recommendations regarding the care of this student? Yes No
 If yes, describe briefly _____

All accepted students have signed a form indicating that they meet all VCOM Technical Standards for Admission and Successful Completion of the Osteopathic Program at VCOM. <https://www.vcom.edu/handbooks/catalog>

On the basis of your history and physical exam do you feel this student is medically able to participate in all educational, physical and patient care activities as a medical student at the Edward Via College of Osteopathic Medicine? Yes _____ No _____

If the answer to the above question is no, please identify any restrictions or physical accommodations that will be required for this student: _____

Signature _____ DO / MD/ NP/ PA
 Address _____
 Office Phone Number _____
 Print Last Name _____ Date _____

Return form to: Student Health Coordinator
Office of Clinical Education VCOM