# MCHD EMS Programs

1400 South Loop 336 West, Conroe, TX 77304 Voice: (936) 523-1140 Fax: (936) 523-5053

## Report of Medical History

| Last Name | First | Middle | Maiden |
|---|---|---|---|
| | | | |

| Address - Number & Street | City | State | ZIP |
|---|---|---|---|
| | | | |

| Phone | Date of Birth | Last 4 of SSN | Sex |
|---|---|---|---|
| | | | |

## Emergency Notification

Person to notify in case of emergency

| Last Name | First | Middle |
|---|---|---|
| | | |

| Address - Number & Street | City | State | ZIP |
|---|---|---|---|
| | | | |

| Home Phone | Work Phone | Pager | Relationship |
|---|---|---|---|
| | | | |

## Personal History

ANSWER ALL QUESTIONS. EXPLAIN "YES" ANSWERS BELOW:

| HAVE YOU HAD? | YES | NO | HAVE YOU HAD? | YES | NO |
|---|---|---|---|---|---|
| Measles (rubeola) | | | Seizures | | |
| Mumps | | | Dizziness, Fainting | | |
| Rubella (German Measles) | | | Weakness, Paralysis | | |
| Chicken Pox | | | Joint Problems | | |
| Diabetes | | | Back Problems | | |
| Tuberculosis | | | Gastrointestinal Problems | | |
| Hepatitis A/B/C | | | Heart Problems | | |
| Visual Impairment | | | Malignancy | | |
| Hearing Impairment | | | Respiratory Problems | | |
| Surgery | | | Hernia | | |
| Recurrent Headache | | | Allergies | | |
| Any UNEXPLAINED weight loss (greater than 10 pounds)? | | | | | |
| Have you had any illness/injury or been hospitalized other than already noted? | | | | | |
| Is your ability to practice safe professional medical care adversely affected by a physical or mental disability/illness which may endanger the health and safety of persons under your care? | | | | | |

EXPLAIN "YES" ANSWERS: _____

_____

_____

_____

(Student) I verify that all of the above is true and complete to the best of my knowledge.

_____ _____

Student Signature Date

**NOTE: BACKSIDE OF FORM TO BE COMPLETED BY HEALTH CARE PROVIDER**

# Report of Health Evaluation

**TO THE EXAMINING PHYSICIAN:** Please review the students' history and complete the physician's form. Please comment on all positive answers. This information will be used only as a background for providing health care, if necessary.

| Student Name | | | SSN |
|---|---|---|---|
| Blood Pressure | Height in inches | Weight in pounds | |

| ARE THERE ANY ABNORMALITIES OF THE FOLLOWING SYSTEMS? | | | |
|---|---|---|---|
| **SYSTEM** | **YES** | **NO** | **COMMENTS** |
| Head/Ears/Nose/Throat | | | |
| Respiratory | | | |
| Cardiovascular | | | |
| Gastrointestinal | | | |
| Hernia | | | |
| Eyes | | | Vision: Lt. Rt. Corrected: Yes No |
| Genitourinary | | | |
| Musculoskeletal | | | |
| Metabolic/Endocrine | | | |
| Neuropsychiatric | | | |
| Skin | | | |
| Gynecological/OB | | | |
| Are there any speech/vision/hearing impairments? | | | |

Recommendations for physical activity (e.g. lifting/moving patients/equipment): _____Unlimited _____Limited

Explain:_____
_____
_____

_____ _____
Physician's Signature Date

_____ _____
Print Last Name First Phone (voice)

_____ _____
Address City State Zip Phone (fax)