TOURO UNIVERSITY
CALIFORNIA

Form B: Physical Exam & Health History

This section to be completed by the student, & reviewed by the HCP. Please use ink and print clearly.

Name _____ Program/Yr. _____Student ID_____

Gender: ☐ M ☐ F Date of Birth: ___/___/___ Telephone Number:_____

Allergies (drugs/food): _____

Medications currently taking: _____

Place a check mark if you currently or have ever had any of the following:

	HEAD		**GASTROINTESTINAL**		**BLOOD DISORDER**
	Major dental problems		Abdominal Pain		Anemia
	Dizziness or Fainting		Recent changes in appetite		Rheumatic Fever
	Encephalitis		Recent changes of bowel habits		Sickle Cell
	EYES/EARS/NOSE/THROAT		Recent constipation		Lymphoma
	Eye trouble		Frequent diarrhea		Other
	Wear glasses		Digestive disorder		**MENTAL HEALTH**
	Wear contact lenses		Difficulty swallowing		Frequent Nightmares
	Allergies		Recurrent emesis (vomiting)		Trouble concentrating
	Ear trouble		Gastric or duodenal ulcer		Cry often
	Hearing problem		Hemorrhoids/Rectal fissures		Feeling of Depression
	Frequent nosebleeds		Other ano-rectal disorders		Tendency to worry
	Hay fever		Hernia		Memory Loss
	Frequent sore throat		Intestinal worms		Metal Health Disorder
	ENDOCRINE		Jaundice		Feelings of loneliness
	Hypothyroid		Black bowel movements		Considerable nervousness
	Hyperthyroid		Vomiting blood		Difficulty Sleeping
	Diabetes mellitus		Intestinal inflammation		Considered Suicide
	CHEST/HEART/LUNGS/VASCULAR		Gall bladder disease		Require use of Sleeping aids
	Breast disease or masses		Hepatitis		Other
	Chest Pain/Pressure		**GENITOUINARY**		**ADDITIONAL MEDICAL HISTORY**
	Heart Disease/Murmur		Urine contains : Blood / Albumin / Sugar		Cancer
	High Blood Pressure		Kidney disease		Unusual fatigue
	Rapid or irregular pulse		Bladder disease		Frequent Colds
	Varicose veins		Painful urination		Serious illness
	Asthma		Frequent urination		Sexual Problems
	Chronic cough		Genital disorder		Skin disorder/infections
	Emphysema		Frequent urinary tract infection		Unexplained weight gain or loss
	Lung Disease		Other		Other
	Night Sweats		**FEMALES ONLY**		**SURGICAL HISTORY**
	Pleurisy		Abnormal pap smear		Appendectomy
	Wheezing		Ovarian cysts		Gall Bladder
	Shortness of Breath		Pelvic inflammatory disease (PID)		Pelvic Surgery
	Coughing up Blood		Pregnancy: G P		Cesarean Section
	INFECTIOUS DISEASE		Painful menses (dysmenorrhea)		Tonsillectomy
	Ambiasis		Fibrocystic disease		Other
	Chicken Pox		Other		
	Coccidiomycosis (Valley Fever)		**MUSCULOSKELETAL/NEUROLOGICAL**		**SOCIAL HISTORY**
	Hepatitis		Arthritis		Smoke Tobacco
	Histoplasmosis		Chronic muscle pain		Alcohol Use
	Intestinal Parasitic Infection		Spine problem, e.g., disc or vertebrae		Recreational Drug Use
	Malaria		Swollen of painful joints/extremities		Other
	Measles / Mumps / Rubella		Bone infection		
	Meningitis		Amputation		**CONDITIONS THAT MAY NOT BE LISTED:**
	Mononucleosis		Speech defect		
	Rheumatic Fever		Cluster headache		
	Scarlet Fever		Migraine headaches		
	Sexually Transmitted Disease		Paralysis , tremors , muscle weakness		
	Tuberculosis		Neuralgia or numbness		

Student Signature_____ Date_____

Reviewed by: _____ Date _____

Provider's name

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Form B: Physical Examination & Health History

To be completed by the physician/healthcare provider.
This can be no more than 6 months old.

Name _____ Date of Birth ____/____/____Program/Yr_____
Last First Middle

BP (sitting) _____/_____ Pulse: _____ Respirations: _____ Gender: M ☐ F ☐

Ht. _____ Wt. _____ Vision: R _____/_____ L _____/_____ Corrected ☐ Uncorrected ☐

EXAMINATION	NORMAL (Please Check)	ABNORMAL (Please Check)	DESCRIPTION
GENERAL: Posture, Gait, Speech, Appearance			
HEAD: Hair, Symmetry, Tenderness			
EYES: Lids, Sclera, Conjunctiva, Muscles.			
EARS: Pinna, Canal, Drum, Hearing			
NOSE: Septum, Obstruction, Mucosa			
MOUTH/THROAT Breath, Lips, Teeth, Tongue, Pharynx.			
NECK: Thyroid, Motion, Trachea, Veins			
LYMPHATICS: Cervical, Supraclavicular, Axillary			
CHEST/LUNGS Symmetric, Percussion, Excursion....			
CARDIOVASCULAR: PMI, Rate, Rhythm, Sound, Murmur…			
ABDOMEN: Tenderness, Organs, Hernia, Masses..			
MUSCULOSKELETAL: Back, Upper extremities, lower…..			
SKIN: Birthmarks, Rashes, Scars, Texture			
NEUROLOGIC DTR's, Biceps, Triceps, Patella, ETC			
MENTAL STATUS: ALOCx3, Affect, Judgment, ETC…..			

Limitations or restrictions: _____

Findings: _____

Please describe any significant emotional problems: _____

Are there any recommendations for continued medical care? Yes ☐ No ☐

If yes, please explain: _____

Healthcare Provider Name: _____ Phone Number_____

Signature: _____ Date _____

Address or Stamp of Healthcare Provider: