VCOM ANESTHESIA BLUEFIELD UNIVERSITY

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: _____

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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 Technical Standards for Admission and Successful Completion of the Master of Health Sciences in Anesthesia Program.

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 student in the Master of Health Sciences Program? 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: _____

_____

Physician's Signature_____**DO / MD**
Address_____
Office Phone Number_____
Print Last Name_____ **Date**_____

Return form to: Student Health Coordinator
Master of Health Sciences in Anesthesia Program