**Indiana University Healthcare Student**
**Health Evaluation**

NAME: _____ GENDER: M / F / T DATE OF BIRTH: _____/_____/_____
(please print legibly) mo day year

**Family History:**

Father:
☐Living
Occupation _____
☐Deceased
Age at death _____
Cause _____

Mother:
☐Living
Occupation _____
☐Deceased
Age at death _____
Cause _____

Siblings:
# living 1 2 3 4 more
# deceased 1 2 3 4 more

Allergies: _____ _____ _____
(Food, medications, environmental)

Surgical History: _____ _____ _____

Medications: _____ _____ _____

Have you or any of your relatives had any of the following? (Please include self (Me), parents (M, F), grandparents (GP), aunts (A), uncles (U), and siblings (S))

| | Y | N | Who, condition | | Y | N | Who, condition |
|---|---|---|---|---|---|---|---|
| Dermatological-eczema, psoriasis, acne | ☐ | ☐ | _____ | Musculoskeletal-arthritis OA,RA,fibromyalgia | ☐ | ☐ | _____ |
| Endocrine-diabetes, thyroid, adrenal | ☐ | ☐ | _____ | Neurological-seizures, migraines, AML,stroke | ☐ | ☐ | _____ |
| Gastrointestinal-GERD,IBD, IBS, PUD | ☐ | ☐ | _____ | Obesity | ☐ | ☐ | _____ |
| GYN/GU-breast, prostate | ☐ | ☐ | _____ | Psychiatric-anxiety, depression, ADD/ADHD | ☐ | ☐ | _____ |
| Hematological-hemophilia, DVT, Leiden V | ☐ | ☐ | _____ | Pulmonary-asthma, COPD, TB | ☐ | ☐ | _____ |
| Heart disease or high blood pressure | ☐ | ☐ | _____ | Visual/hearing problems | ☐ | ☐ | _____ |
| Immunological-lupus, scleroderma, MS | ☐ | ☐ | _____ | other | ☐ | ☐ | _____ |
| Kidney-stones, pyelonephritis, failure | ☐ | ☐ | _____ | | | | |

**Lifestyle:**

Diet:
☐Regular ☐Low fat
☐Vegetarian ☐Gluten-free

Exercise:
☐None ☐Light
☐Moderate ☐Heavy

Do you use any of the following?
Tobacco ☐No ☐Yes Alcohol ☐No ☐Yes
Dietary Herbs/Supplements ☐No ☐Yes Caffeine ☐No ☐Yes

Comments _____

## PHYSICAL EXAM:

**General Overall Appearance**:

Height _____ Weight _____ BMI_____ Blood Pressure _____Temp_____ HR _____Respiratory Rate _____

Skin _____ Head _____ Eyes _____ Ears _____ Nose _____ Throat _____

Lymphadenopathy_____ Neck/Thyroid_____ Heart _____

Chest_____ Spine _____ Abdomen_____

Extremities _____ Neurological _____

Visual acuity: R 20/ L 20/ Both 20/ ☐with ☐without correction Color Vison R/G/Y: ☐Normal ☐Abnormal

Comments: _____

## PROVIDER EVALUATION:

Student is determined to be physically and mentally able to attend academic program: ☐Yes ☐No

Provider Recommendations: ☐No ☐Yes-explain: _____

Limitations: ☐No ☐Yes-explain: _____

Date _____ Signed _____ _____
(M.D/D.O or N.P/P.A Signature) (Provider's name printed)

## OFFICE STAMP:

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