COLLEGE OF MICRONESIA - FSM

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STUDENT HEALTH SERVICE

HEALTH EXAMINATION FORM

1 Name (*Last Name, First Name, Middle Name*)

2 Date

3 Marital Status ☐ Single ☐ Maried ☐ Widow
Name of Spouse: ____________

4 Sex ☐ Male ☐ Female

5 Date of Birth (*MM/DD/YY*)

6 Mailing Address (*P.O. Box Street, City, State, Country, ZIP Code*)

7 Phone and Fax Numbers

8 Email Address

Person to be notified in case of emergency

9 Name of Next of Kin (*Last Name, First Name, Middle Name*)

10 Relationship

11 Phone and Fax Numbers (*Next of Kin*)

12 Mailing Address (*P.O. Box Street, City, State, Country, ZIP code*)

13 Citizenship ☐ Micronesian ☐ Others, specify ____________

LABORATORY

BLOOD		URINALYSIS		STOOL FOR O AND P		DATE RX	BACTERIOLOGY	
Kahn/VDRL		Sugar		Ascaris			Gramstain for Gonococcus	
Hemoglobin		Albumen		Amoeba			**Have you any physical disability? If yes, Please explain**	
Hematocrit		Micro		Hookworm				
Type/RH								
Filariasis								

Height	Weight	Pulse	Blood Pressure
Vision (Left)	Vision (*Right*)	Hearing (*Left*)	Hearing (*Right*)

IMMUNIZATIONS

	Dates
Measles	
Mumps	
rubella	
Polio (Oral)	
DPT or DT	
BCG	
Covid-19	
PPD Test	
Date Read	
Result (mm)	
X-Ray (if PPD+)	

FAMILY HISTORY

Have any of your family members or relatives had any of the following diseases?

Have they had	Yes	No	Relationship	Have you had	Yes	No
Tuberculosis				Heart Disease		
Leprosy				Kidney Disease		
Diabetes				Hepatitis		
High Blood Pressure				Stomach Ailment		
Arthritis				Asthma, Hay Fever		
Epilepsy				Other Disease (s)		
Convulstions						
Convulstions						

PERSONAL HISTORY

Pelease indicate YES or NO in all questions. Make appropriate comments in the space provided

Have you had	Yes	No	Have you ever had	Yes	No	Have you frequently have	Yes	No	Comments
Rheumatic Fever			Tuberculosis			Insomia (Can't sleep)			
Measles			Amoebiasis			Anxiety, Worry			
German Measles			Filariasis			Depression			
Mumps			Ascariasis			Nervousness			
Polio			Hookworm			Stomach trouble			
Hepatitis			Pain in the chest			Diarrhea			
Chicken Pox			High blood pressure			Dizziness, Faintness			
Cholera			Diabetes			Palpitation			
Leprosy			Kidney disease			Headaches			
Venereal Disease			Epilepsy			Cold, Sore throat			

Have you had	Yes	No	**List below all medical treatments and/or medications that you are currently undergoing and the reasons for them:**
Any Surgery			
tumor or Cancer			
Hay Fever			
Allergy			
Asthma			

GENERAL QUESTIONS	YES	NO	COMMENTS
1. Has a doctor ever denied or restricted your participation in sports for any reasons?			
2. Have you ever spend the night in the hospital?			
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**	**COMMENTS**
3. Have you ever passed out or nearly passed out DURING or AFTER exercise?			
4. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			
5. Does your heart ever race or skip beats (irregular beats) during exercise?			
6. Has a doctor ever ordered a test for your hea			
7. Do you get lightheaded or fell more short of breath than expected during exercise?			
8. Have you ever had an unexplained seizure?			
BONE & JOINT QUESTIONS ABOUT YOU	**YES**	**NO**	**COMMENTS**
9. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss practice or game?			
10. Have you ever had any broken or fractured bones or dislocated joints?			
11. Hve you ever had a stress fracture?			
12. Do you regularly use a brace, orthotics, or other assistive devices?			
13. Do you have a bone, muscle, or joint injury that bothers you?			
14. Do any of your joints become painful, swollen, feel wqarm, or look red?			
MEDICAL QUESTIONS	**YES**	**NO**	**COMMENTS**
15. Have you ever tested positive for any sexually transmitted disease or infection?			
16. Do you chew tobacco/betelnut, drink, or smoke?			
17. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
18. Have you ever had an inhaler or taken asthma medicine?			
19. Do you have groin pain or painful bulge or hernia in the groin area?			
20. Have you had infectious mononucleosis within the last month?			
21. Do you have rashes, pressure sores, or other skin problems?			
22. Have you had a herpes or MRSA skin infection?			
23. Have you ever had a head injury or concussion?			
24. Have you ever had a hit or vlow to the head that caused confusion, prolonged headache, or memory problems?			
25. Do you have headaches with exercise?			
26. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?			
27. Have you ever become ill while exercising in the heat?			
28. Do you get frequent muscle cramps when exercising?			
29. Have you had an ey injuries?			
30. Do you worry about your weight?			
31. Are you trying to or has anyone recommended that you gain or lose weight?			
32. Are you on a special diet or do you avoid certain types of food?			
33. Have you ever had an eating disorder?			
34. Do you have any concerns that you would like to discuss with your doctor?			
FEMALES ONLY	**YES**	**NO**	**COMMENTS**
35. Have you ever had a mesntrual period?			
36. When was your last menstrual period?			
37. How old were you when you had your first mesntrual period?			
38. How many periods have you had in the last 12 months?			
39. Are your periods regular each month? Do they come at the same time each month?			
40. Have you ever been pregnant?			

SUMMARY	
My examination revealed:	CHECK ONE
CLEARED FOR ALL SPORTS WITHOUT RESTRICTION	
CLEARED FOR ALL SPORTS WITHOUT RESTRICTION WITH FURTHER EVAUATION OR TREATMENT FOR:	
NOT CLEARED: Pending further evaluation	
NOT CLEARED: For Any Sports	
NOT CLEARED: For certain sports Reason:	
RECOMMENDATIONS:	

I have examined the above-names student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contrindications to practice and or participate in sports(s) outlined above. A copy of the physical exam is on record in my office and can be made available upon request. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resoved and the potential consequences are completely explained to the athlete (and parent/guardian for minors).

______________________________ Physician's Signature (Over Printed Name)

______________________________ Date