Trinity Washington University Health & Wellness Center
125 Michigan Ave. N.E. Washington, DC 20017 P:202-884-9615 Fax: 202-884-9614

Student Health History & Physical Examination

HEALTH HISTORY (This form is to be filled out by the **STUDENT** prior to your physical exam)

Student Name: _____ DOB: ____/____/____

Home Address: _____ Phone #:_____

Have you EVER been diagnosed with the following?

	Y	N	Comment		Y	N	Comment
Allergies (food, environment, drug)				Diabetes or Blood Sugar problems			
Asthma or Breathing Problems				Headaches/Head Injuries/Concussion			
Behavioral/Emotional Problems				Hearing Problems			
Bleeding Problems or Sickle Cell Disease				Muscle/joint problems			
Bladder/Urinary Problems				Seizures			
Bowel/Stomach Problems				Surgeries			
Ear/Nose or Throat Conditions				Vision problems			
Heart problems or High Blood Pressure				Skin problems			

Have you ever passed out DURING or AFTER exercise? _____

Does your heart race or skip a beat during or after exercise? _____

Do you get lightheaded or short of breath with exercise? _____

Have you been hospitalized in the past 5 years? _____

Does anything limit your ability to participate in school activities? _____

Have you taken the covid-19 test? If so what were your results and date. _____
_____

Have you taken the covid-19 vaccine? _____. If so please attach card as proof.

ACTIVE MEDICAL PROBLEMS: _____
_____

PERTINENT FAMILY MEDICAL HISTORY: _____
_____

STUDENT SIGNATURE _____ Date: _____

Student Name: _____ DOB: ____/____/____

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PHYSICAL EXAMINATION (This form is to be filled out by the **medical provider**)

Date of Physical Exam: ____/____/____ (due annually)

VITAL SIGNS:

Height: _____ Weight: _____ BP: _____/ _____ HR: _____ RR: _____ Pulse Ox: _____

ALLERGIES

Medications NO YES (Please list) _____
Do they carry an Epi- Pen? NO YES (last time used?) _____

ACTIVE MEDICAL PROBLEM LIST:

_____
_____
_____

CURRENT MEDICATIONS: (Please list any prescription, OTC, herbal medications, Birth control)

Rx Name Dose Indication

_____
_____
_____

Place a checkmark for each system (denote NE if not evaluated)	Normal	Abnormal	If abnormal, please comment:
Appearance:			
Neck:			
HEENT:			
Lungs/ Chest			
Heart (Include any murmur /defect)			
Abdomen (include hernia)			
Musculoskeletal/Extremities			
-Neck			
-Head			
-Back			
-Shoulder			
-Elbow			
-Wrist			
-Hand			
-Knee			
-Ankle			
-Foot			
Skin			
Neurologic			
Psychiatric			

Student Name: _____ DOB: ____/____/____

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REQUIRED IMMUNIZATIONS: (This form is to be filled out by the medical team)

Lab reports MUST accompany this form if reporting immunity by titer. If any component of the titer is negative or equivocal, the entire vaccine series should be repeated.

Vaccine	Date(s) Given	Staff Initials
T/DAP	1)	
MMR	1) 2)	
Polio	1) 2) 3) 4)	
Hepatitis B	1) 2) 3)	
Varicella	1) 2)	

Residential Students & Student-Athletes are required to have the Meningococcal Vaccine

Meningococcal vaccine	Date(s) given	Staff Initials
	1) 2)	

Nursing & Health Professions students are required to have an annual Flu shot

Flu shot (annual)	Date given	Lot #	Expiration date

TUBERCULOSIS SCREENING (choose one method):

1) PPD/Tuberculin Skin Test Placed on : ____/___/____
Date Read: ____/___/____ Result: _____ mm
Negative: _____ Positive: _____

- If positive, please submit a copy of the medical record that documents the positive PPD results (date given, date read, and size of induration) **AND** negative Quantiferon Gold blood test **OR** a clear chest x-ray report within the past 2 years **AND** TB questionnaire.

- If previous results proved positive, submit a negative Quantiferon Gold (every year) OR clear chest x-ray report (every 2 years) **AND** TB Questionnaire **AND** any medical recommendations for treatment.

2) Quantiferon Gold Date : _____ (due annually) Result_____ (attach lab result)

- If Quantiferon Gold is indeterminate or positive, a negative chest x-ray is required within the past 2 years.

  If a chest x-ray was required for a + PPD or Abnormal Quanitferon, please submit the corresponding radiology report. If the CXR was abnormal, please submit the medical treatment plan/recommendations.

Student Name: _____ DOB: ____/____/____

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Cleared for full participation in all school activities? **Yes ____ No____**

Cleared for full participation in sports/physical activity? **Yes ____ No____**

Cleared for full participation in all clinical/fieldwork rotations? **Yes ____ No____**

If no, what are the restrictions?

_____
_____
_____
_____

Printed name of Examining Provider _____MD/DO/NP/PA

Provider Signature_____ Date_____

Office Street Address _____

City_____ State_____ Zip Code_____

Telephone (____)_____Fax (____)_____

Mail completed forms to:

Health & Wellness Center
125 Michigan Ave NE 4th Fl
Washington, DC 20017