UNITED TRIBES TECHNICAL COLLEGE
3315 UNIVERSITY DRIVE
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UNITED TRIBES TECHNICAL COLLEGE
Statement of Medical Examination

Name_____ Date of Birth_____

Address_____

If Minor, Name of Parent/Guardian: _____

Past Medical History:

DISEASES/ILLNESS

Disease	When Diagnosed	Treatment	Resolved Chronic Or Freq. Occurrence
Hypertension			
Diabetes			
Heart Disease			
Kidney Disease			
Tuberculosis			
Seizures			
Anxiety/Nervous Reactions			
Ulcers/Gastritis			
Resp. Infections			
Gastroenteritis			
Ear Infections			
Alcoholism			
Musculoskeletal			
Other			

HOSPITALIZATION/SURGERIES

Where	When	Why

B/GYN hx. P._____G._____ Pap_____

Allergies, food sensitivity

IMMUNIZATIONS:

DPT._____ _____ _____ _____ _____

OPV._____ _____ _____ _____ _____

DT._____ MMR_____ PPD_____

Current Medications:_____

OVER

Will this person need:

	YES	NO
1) Follow up for any Med.Surg. Problem? _____	☐	☐
2) Glasses?_____	☐	☐
3) Dental work?_____	☐	☐
4) Immunizations?_____	☐	☐
5) Hearing Evaluation?_____	☐	☐

Physical Exam: Wt._____ Ht._____ B/P_____ Vision_____
Hearing: Normal_____ Abnormal_____

	Normal	Abnormal		Normal	Abnormal
HEENT			Extremities		
Neck			Musculosketetal		
Thorac			Spine		
Breast/Axillac			Skin		
Lungs			Genitalia		
Heart			Neurological		
Abd.			Mental Status		

If abnormal, please explain:_____

Lab

Hct_____	UA_____

Other comments:_____

Service Unit_____ MD Signature_____Date_____