Iowa State University
Dietetic Internship Program
Medical Examination Report

Complete and submit no later than Monday of Pre-MNT Workshop Week
This can be emailed, faxed or returned in person.
Note: This is completed after the intern has accepted a position with ISU.

This information is strictly for the use of the ISU Dietetics Internship Program and will not be released to anyone without the student's knowledge and written consent. Please make a copy for your personal records.

Name	Age	Birthdate	Marital Status	Sex

Physician Name	Physician's Phone #
Address of Physician (Include city, state, zip)	Physician's Fax #

In an emergency, call ______________________________ ☐ Parent ☐ Guardian ☐ Spouse
name of person

Address ______________________________ Phone # (home) ______________
street address

______________________________ Phone # (work) ______________
city, state, zip code

Previous Illnesses

Previous Surgeries

Previous Injuries

Medical History

PERSONAL HEALTH HISTORY

1. **Allergies:** Have you ever had any allergic reactions? ☐ Yes ☐ No

   If yes, list any allergies to:

   Medications ______________________

   Other (latex, bee/wasp stings, seasonal, etc.) ______________________

2. **Childhood Diseases:** Have you ever had the following diseases?

   a. Chickenpox ☐ YES ☐ NO

   b. Mono (Mononucleosis) ☐ YES ☐ NO

   c. Other (Please specify): ______________________

3. **Disease History:** Have you, or a biological family member (father, mother, sibling, child), ever had any of the following:

YOU			FAMILY MEMBER	
☐ YES	☐ NO	Abnormal bleeding tendency	☐ YES	☐ NO
☐ YES	☐ NO	Alcohol or other substance abuse problem	☐ YES	☐ NO
☐ YES	☐ NO	Anemia	☐ YES	☐ NO
☐ YES	☐ NO	Arthritis	☐ YES	☐ NO
☐ YES	☐ NO	Asthma	☐ YES	☐ NO
☐ YES	☐ NO	Cancer	☐ YES	☐ NO
☐ YES	☐ NO	Convulsions or seizures	☐ YES	☐ NO
☐ YES	☐ NO	Depression	☐ YES	☐ NO
☐ YES	☐ NO	Diabetes	☐ YES	☐ NO
☐ YES	☐ NO	Diseases of the colon	☐ YES	☐ NO
☐ YES	☐ NO	Eating disorder	☐ YES	☐ NO
☐ YES	☐ NO	Gallbladder and/or liver disease	☐ YES	☐ NO
☐ YES	☐ NO	Hay fever	☐ YES	☐ NO
☐ YES	☐ NO	Heart disease (murmur, palpitations, etc.)	☐ YES	☐ NO
☐ YES	☐ NO	High blood pressure	☐ YES	☐ NO
☐ YES	☐ NO	HIV infection	☐ YES	☐ NO
☐ YES	☐ NO	Kidney disease	☐ YES	☐ NO
☐ YES	☐ NO	Malaria	☐ YES	☐ NO
☐ YES	☐ NO	Orthopedic problems (e.g., knee, etc.)	☐ YES	☐ NO
☐ YES	☐ NO	Severe headaches (e.g., migraine, etc.)	☐ YES	☐ NO
☐ YES	☐ NO	Thyroid problems	☐ YES	☐ NO
☐ YES	☐ NO	Tuberculosis	☐ YES	☐ NO
☐ YES	☐ NO	Ulcer	☐ YES	☐ NO

Please indicate any other medical problems you or your family have ______________________

4. **Surgeries:** Please list dates and reasons for any surgical procedures (e.g., appendectomy, tonsillectomy, hernia, etc.)

   ____

5. **Injuries:** Please describe any previous injuries, such as concussions, fractures, etc.

   ____

6. **What medicines do you take regularly?** (prescription and non-prescription drugs, vitamins, birth control pills, etc.)

   ____

7. **Have you ever been hospitalized?** ☐ YES ☐ NO

   If yes, reason(s)

Immunization Record

NOTE:
All immunizations must be current.

Intern must provide proof of immunizations upon request.

ISU Dietetics Internship does not require Hepatitis B vaccination because the intern typically does not participate in activities that might result in Hep B contamination; intern's participating experience location may require intern to sign a waiver stating they do not wish to pursue Hep B vaccination.

Intern must have two documented TB Mantoux/PPD tests; one within past three months. If positive Mantoux/PPD test, then must have negative chest X-ray.

Intern must have two-documented MMR (or proof of immunity after 1980) and Rubella vaccination or an acceptable Rubella titre.

IMMUNIZATIONS REQUIRED OF ALL DIETETIC INTERNS:
Proof of immunizations or immunity is required.

TUBERCULOSIS SKIN TEST (Mantoux/PPD)

☐ Positive ☐ Negative ____________mm of induration date of test ________/_______/_______

MEASLES (Rubeola) Immunity: Please check one of the four options.

1. ☐ I have had two doses of live measles vaccine:

First Dose
___________/___________/__________
Must be on or after first birthday

☐Measles, Mumps, Rubella
☐Measles, Rubella
☐Measles Month Day Year

Second Dose
Must be given in 1980 or later
__________/___________/___________
and at least 30 days after first dose

☐Measles, Mumps, Rubella
☐Measles, Rubella
☐Measles Month Day Year

____
Signature of Licensed Health Care Provider (OR attach shot record or documentation) Date

2. ☐ I have had a Measles (Rubeola) titer (blood test) showing immunity (copy of blood test is attached)
3. ☐ I have had Measles (Rubeola) disease (Health Care Provider documentation of rubeola with date of disease attached)
4. ☐ I am exempt because I was born before January 1, 1957

NON U.S. CITIZEN STUDENTS ARE REQUIRED TO HAVE TUBERCULOSIS TESTING DONE AFTER ARRIVING IN THE U.S.*

IMMUNIZATIONS RECORD: (Please record date of vaccination or attach a copy of your records.)

Date of last vaccination (month/day/year)		**Date of last vaccination (month/day/year)**	
Mumps	______/_____/______	Rubella	______/_____/_____
Tetanus/diphtheria (Td)	______/_____/______	Polio (IPV or OPV)	______/_____/_____

Physical Examination

To be completed by physician or health care provider

(N = Normal or Negative, O= Not Examined)

Height	Weight	
Eyes	Hearing	
Ears	Teeth	
Throat	Dental	
Lymph Nodes	Thyroid	
Chest	Breasts	
Heart	Pulse	Blood Pressure
Abdomen	Hernia	
Genitourinary	Rectal	
Extremities	Joints	
Skin	Reflexes	

Are there any defects in the legs or feet, which limit the ability to stand or walk for long periods? If yes, please explain:
Are there any defects in the back, which would limit the ability to lift? If yes, please explain:
Are there any defects, which indicate the need for surgery? If yes, please explain:
Is there any reason why the intern may be unable to: • satisfactorily complete the 6-month internship? If yes, explain. • provide safe patient/client nutrition care? If yes, please explain.

Intern is: ( ) Physically fit for internship and free of transmissible diseases

( ) Physically fit for internship pending reports on laboratory and X-ray tests.

( ) Physically disqualified for internship due to:

Physician's Recommendations/Additional Comments:

Physician Signature ____ **Date** _________________________