

**Physical Examination Report**

**Please complete Part I & Part II.  
Part III must be completed by physician**

**Part I            Personal Information**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact (name) \_\_\_\_\_ Phone # \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone # \_\_\_\_\_

**Part II            Medical History (Date need not be exact, month & year only  
Regarding operation & injuries)**

A. Check disease or illness that you have had:

Measles	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Mumps	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Cardiac Problems	<input type="checkbox"/>

Other serious disease \_\_\_\_\_

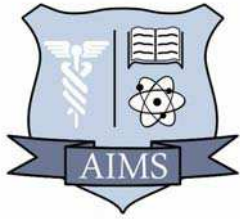
Allergies to Medicines/Latex allergy screen/other: \_\_\_\_\_

Injuries/ Medical & Surgical History: \_\_\_\_\_

List medication(s) taken on regular basis: \_\_\_\_\_

B. Immunizations:

1. Measles vaccination: (required unless immune or have had 2 doses since 1<sup>st</sup> birthday) – Date \_\_\_\_\_
  2. Hepatitis B Vaccination : Date # 1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_
  3. Varicella (Chicken Pox): Date of Titer: \_\_\_\_\_
  4. If have not had titer but have chicken Pox, please indicate date of case: \_\_\_\_\_
  5. Rubella Titer: Date: \_\_\_\_\_
  6. Varicella Titer: Date: \_\_\_\_\_
- Two steps TB test (if previously TB negative): Date: \_\_\_\_\_  
One TB test with in last calendar year



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I hereby confirm that the information provided by me is true, complete and correct to the best of my knowledge and belief.

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Part III Physical Examination (to be completed by physician)**

**General Condition**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Hearing Vision \_\_\_\_\_

Extremities: \_\_\_\_\_ Back & Spine: \_\_\_\_\_

Students are required to function successfully in the following performance areas to complete an allied health occupation program.

1. Provide support to patient during walking, standing or getting in or out of bed or chair (support or lift 50 pounds)
2. Communicate with patient, family, or healthcare provider verbally.
3. Provide written documentation.
4. Observe visual changes in patient and/or environment for proper documentation.
5. Provide manual dexterity to operate keyboard, dials and apparatus utilized in the patient care and/or records area.

Is this applicant physically and emotionally qualified to participate in all classroom and clinical activities of an allied health occupation? \_\_\_ Yes \_\_\_ No (If no, please comment and attach additional pages if necessary)

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Physician Signature \_\_\_\_\_

Physician's Name (Print) \_\_\_\_\_

Address \_\_\_\_\_

Phone: \_\_\_\_\_