



# TEXAS COLLEGE MEDICAL EXAMINATION FORM

All Information kept Confidential



Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Last First Middle  
City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: M/F (Please Circle)

Name of person case of emergency: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_

### I. Record of illness: (Check those that occurred within the past five (5) years).

Frequent Colds _____	Allergies _____	Bone Disease _____
Influenza _____	Chickenpox _____	Skin Disease _____
Bronchitis _____	Hernia _____	Diabetes _____
Pneumonia _____	Cholera _____	Kidney Disease _____
Tuberculosis _____	Rheumatic Fever _____	Other _____
Asthma _____	Specify: _____	

### II. Have you had any of the following to occur? (Check those that occurred within the past five (5) years).

Blurred Vision _____	Leg Pains _____	Vomiting _____
Recurring Headaches _____	Palpitation _____	Sore Throat _____
Blackouts _____	Respiratory Problems _____	Abdominal Pains _____
Fainting Spells _____	Frequent Urination _____	Constipation _____
Painful Joints _____	Problems Urinating _____	Nosebleed _____
Backaches _____	Cough (prolonged) _____	Hepatitis _____

### III. Physical Examination (Must See A License Physician To Complete This Section):

<u>AREA</u>	<u>COMMENTS</u>	<u>AREA</u>	<u>COMMENTS</u>
Skin: _____	_____	Lymph Glands _____	_____
Eyes: _____	_____	Chest: _____	_____
Nasopharynx: _____	_____	Lungs: _____	_____
Tonsils: _____	_____	Heart: _____	_____
Thyroid: _____	_____	Genitalia: _____	_____
Blood Pressure: _____	_____	Pulse: _____	_____
Urine (Albumin): _____	_____	Microscope: _____	_____
(Specific Gravity): _____	_____	Diabetes: _____	_____
Hemoglobin: _____	_____	Allergies: _____	_____

**Immunization for Bacterial Meningitis: \_\_\_\_\_ (High Importance)**

Mental or Emotional Disorders: \_\_\_\_\_

Recommendations: \_\_\_\_\_

I hereby certified that this student has been examined by me and is mentally and physically able to enroll in this school.

\_\_\_\_\_  
Examining Physician's Signature

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physical Address

\_\_\_\_\_  
City/St

\_\_\_\_\_  
Zip