BROWARD COLLEGE
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BROWARD COLLEGE NURSING PROGRAM
MEDICAL HISTORY & PHYSICAL EXAM UPDATE FORM

Last Name	First Name	Student ID #

Review of Systems / Medical History — please check all that apply			
Abnormal Bleeding		Hepatitis	
Allergies – Latex, Penicillin, Ampicillin, Other		Hernia	
Anemia		High Blood Pressure	
Anxiety		High Cholesterol	
Arthritis		Intestinal / Stomach Trouble	
Asthma		Low Back Condition / Scoliosis	
Cancer of		Mononucleosis	
Chest Pain		Neck Condition	
Chronic Cough		Neurological Disorder	
Concussion / Head Injury		Orthopedic Disorder	
Emotional Disturbance		Prior Surgery	
Depression		Rheumatic Fever	
Diabetes		Seizure Disorder	
Ear Trouble / Hard of Hearing		Sickle Cell Trait	
Eating Disorder		Sinus Problems	
Eye Trouble / Vision Loss		Skin Disease	
Fracture of ________________		Splenectomy	
Gallbladder Disease		Sprain of __________________	
Headaches / Migraines		Syncope / Fainting	
Heart Murmur or Arrhythmia		Thyroid Disease	
Heart Problems (other)		Tuberculosis	

Mantoux PPD – Tuberculin Test and/or CXR required annually – within past 12 months		
PPD Test Date	Attach supporting documentation	
Date & Time Administered	Administered by	
Manufacture of PPD	Expiration Date	Lot Number
Date Read	Read By	
Results in Millimeters of Induration		
If results are positive or restricted from a PPD due to the BCG vaccine, a chest X-ray is required		
Chest X-ray Date	Attach Results of Chest X-ray	Examiner's Initials

Flu Vaccine - seasonally between September 15 & March 31		
Date of Vaccine	Injection Site	Attach supporting documentation
Lot Number	Expiration	Examiner's Initials

Please indicate any health concerns that you presently have and provide information regarding any of the boxes checked above.

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Information detailed on the Medical History and Physical Examination form is legally privileged and confidential. It is intended for use by the Health Science program unless written consent has been provided for release to other parties.

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Examiner: Please examine this student as you would for a routine check-up. This student will be working closely with people in various health care settings. Please indicate/comment on any abnormal findings; using additional sheets if necessary or providing further documentation.

HEIGHT: ____________ **WEIGHT:** _________ **BLOOD PRESSURE:** __________

SYSTEM	NORMAL	FINDING	COMMENTS/PREVIOUS CONDITIONS/SURGERY
Cardiovascular			
Endocrine/Metabolic			
Eyes/Ears/Nose /Throat			
Gastrointestinal			
Genitourinary			
Integumentary			
Musculoskeletal			
Neurological			
Respiratory			

Is the student under treatment for any medical, surgical or emotional/psychological condition? **YES** **NO**
If yes, please provide details:

____

Is the student now taking any medications? **YES** **NO**
If yes, please list:

____

Is the student limited from participating in physical activities in the clinical area? **YES** **NO**
If yes, please specify limitations:

____

Does the student require any follow-up health supervision? **YES** **NO**
If yes, please specify:

____

Within the last 5 years, has the student been treated for any substance related (drug/alcohol) disorder? **YES** **NO**
If yes, please specify:

____

EXAMINER'S NAME (PLEASE PRINT)____________________________________ **PHONE** __________________

ADDRESS____ **CITY**_______ **STATE** ________ **ZIP**_________

SIGNATURE OF MD/DO/ARNP _______________________________________ __ **DATE** ____________________

LICENSE # ____

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