



## MEDICAL HISTORY AND PHYSICAL EXAMINATION RECORD FOR TUTTLE CLINIC, NORTH GREENVILLE COLLEGE, TIGERVILLE, S.C. 29688

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Sex \_\_\_\_\_

Home Address \_\_\_\_\_ Telephone No. \_\_\_\_\_

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

Parent or Guardian \_\_\_\_\_ Telephone No. (res.) \_\_\_\_\_

Telephone No. (work) \_\_\_\_\_

Address \_\_\_\_\_

Circle year entering college:    1    2    Expected enrollment date \_\_\_\_\_

If transfer, name college last attended \_\_\_\_\_

Name of family physician \_\_\_\_\_ Telephone No. \_\_\_\_\_

Address \_\_\_\_\_

### PLEASE READ CAREFULLY BEFORE COMPLETING HISTORY

**IMPORTANT:** Legal safeguards make it necessary for every student to have on file in the Health Services Office a record of medical history and physical examinations. The physical examination is not available through North Greenville's Health Services. However, receipt of this form by the Health Services prior to the student's enrollment fulfills that requirement.

Get your physical, have your doctor sign this form and mail it directly to:

**Tuttle Clinic / North Greenville College / Tigerville, S.C. 29688**

The primary purposes of this medical record are to provide a basic point for reference in case of future illness, to locate possible medical conditions needing correction before it can interfere with your studies, and to provide the health service staff with knowledge of any necessary continuing treatments. It is also used to determine your fitness for any physical training that may be required by the College.

All information revealed will be considered confidential and will not interfere with acceptance into the College unless such findings would endanger the other students or staff.

The history portion should be carefully and completely filled out by the applicant with the help of his or her parents. This should be done **BEFORE** going to your physician for completion of the physical examination section. The physical examination can be done by any licensed medical doctor, but preferably your family physician who is more familiar with your background. He will review and help with any problems incurred with the history position.

**All listed immunizations must be completed and up to date.**

Incomplete documentation of these will prevent registration.

**All falsification on the record will make the applicant liable to automatic dismissal from the college.  
THIS FORM MUST BE FULLY COMPLETED AND RETURNED IN ORDER TO REGISTER!**

### MEDICAL HISTORY

FAMILY	IF LIVING			IF DECEASED	
	Age	Occupation	State of Health	Age at Death	Cause of Death
<b>Father</b>					
<b>Mother</b>					
<b>Brothers</b>					
<b>Sisters</b>					

List family history of any hereditary disease such as diabetes, hypertension, heart disease, etc.: \_\_\_\_\_

### PERSONAL HISTORY

#### PAST HISTORY

Have you EVER had:

	Yes	Age	No		Yes	Age	No
Asthma				Chicken Pox			
Diabetes				Measles (Rubeola)			
Epilepsy or other Seizure Disorder				Mumps			
Pneumonia				Rubella (German Measles)			
Recurrent Bronchitis				Infectious Mononucleosis			
Surgery				Other			

Explain "Yes" answers briefly: (Physician will explain technical details) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have drug allergies? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_  
 \_\_\_\_\_

Are you now taking any medication regularly? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_  
 \_\_\_\_\_

#### CURRENT HISTORY

Do you have a disease, condition, or any physical handicap? Explain "Yes" answers briefly listing medications, so that the medical staff of Tuttle Clinic might better serve you. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever had treatment for nervous or emotional illness? \_\_\_\_\_ If so, explain \_\_\_\_\_  
 By whom were you treated? (Name) \_\_\_\_\_  
 (Address) \_\_\_\_\_

If female, indicate menstrual history. Menses regular? \_\_\_\_\_ Painful? \_\_\_\_\_  
 Any medication used for cramps, regulation, etc., specified \_\_\_\_\_

\_\_\_\_\_  
 Signature of Applicant

#### PARENTAL PERMIT

**Law requires parental permission before operative procedures on minors.** No operation will be performed except in extreme emergency without parents being contacted and informed. To care for such emergencies, it is desirable that the parent sign the following form.

I hereby authorize the medical staff of Tuttle Clinic to prescribe and have performed any operation deemed an emergency on \_\_\_\_\_  
 \_\_\_\_\_

Date \_\_\_\_\_ Parent's Signature \_\_\_\_\_

# IMMUNIZATION RECORD

Name \_\_\_\_\_ SS # \_\_\_\_\_  
PRINT (LAST) (FIRST) (MIDDLE)

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Tuttle Clinic **REQUIRES** the following immunizations upon the recommendation of the American College Health Association and South Carolina Department of Health: (Note: Physicians or clinic verification is necessary.)

**ALL DATES MUST INCLUDE MONTH, DAY, AND YEAR**

DPT, DT, or dT (Circle one) — Must be given within the last 9 years.

Date: Mo \_\_\_\_\_ Day \_\_\_\_\_ Yr \_\_\_\_\_

POLIO — Date series completed: Mo \_\_\_\_\_ Day \_\_\_\_\_ Yr \_\_\_\_\_

MUMPS — Date: Mo \_\_\_\_\_ Day \_\_\_\_\_ Yr \_\_\_\_\_

MEASLES (Rubeola) — **Proof of 2 doses.** 1st dose must be given after 1st birthday.

Dates: #1 Mo \_\_\_\_\_ Day \_\_\_\_\_ Yr \_\_\_\_\_

#2 Mo \_\_\_\_\_ Day \_\_\_\_\_ Yr \_\_\_\_\_

RUBELLA (German Measles) — Must be given after 1st birthday.

Date: Mo \_\_\_\_\_ Day \_\_\_\_\_ Yr \_\_\_\_\_

TUBERCULIN skin test within the last year. Type \_\_\_\_\_ Results \_\_\_\_\_

Date: Mo \_\_\_\_\_ Day \_\_\_\_\_ Yr \_\_\_\_\_

NOTE: If skin test is positive, a chest x-ray is required within 6 months prior to registration for classes.

Date \_\_\_\_\_ Results \_\_\_\_\_ Treatment (if necessary) \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature or Clinic Stamp

## LABORATORY DATA

Urinalysis: S \_\_\_\_\_ Specific Gravity \_\_\_\_\_

A \_\_\_\_\_ Microscopic \_\_\_\_\_

Hemoglobin \_\_\_\_\_ gm.

## PHYSICAL EXAMINATION

Weight \_\_\_\_\_ Height \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Visual Acuity: (Snellen) Uncorrected \_\_\_\_\_ Corrected \_\_\_\_\_

1. Corrective lens: Yes \_\_\_\_\_ No \_\_\_\_\_

2. Glasses? Yes \_\_\_\_\_ No \_\_\_\_\_

### PHYSICIAN'S EVALUATION

#### I. HISTORY

Have you treated the applicant for any significant disease or medical problem other than minor short term illnesses?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list problem with any suggestions regarding follow-up care and treatment while the applicant is under our supervision: \_\_\_\_\_

\_\_\_\_\_

Please list any previous or existing illnesses and treatment. Attach copy(s) of evaluation. \_\_\_\_\_

\_\_\_\_\_

#### II. PHYSICAL EXAM

A. Normal in every respect \_\_\_\_\_

B. Abnormalities \_\_\_\_\_

If so, please explain:

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

### PHYSICIAN'S RATING

Do you consider this student physically and emotionally capable of doing satisfactory college work? Yes \_\_\_\_\_

No \_\_\_\_\_ Doubtful \_\_\_\_\_ Give reasons if no or doubtful \_\_\_\_\_

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

In your opinion is he or she physically qualified for: Unrestricted athletics or exercise \_\_\_\_\_

Restricted athletics or exercise \_\_\_\_\_ Basis for restriction \_\_\_\_\_

What level of restriction? \_\_\_\_\_

Is restriction permanent? (yes or no) \_\_\_\_\_ Temporary? (yes or no) \_\_\_\_\_ How long? \_\_\_\_\_

Special diet or other dietary considerations? Explain \_\_\_\_\_

\_\_\_\_\_

Date of Examination \_\_\_\_\_

Signature of Examining Physician \_\_\_\_\_, M.D.

Typed or Printed Name of Physician \_\_\_\_\_

Address of Physician: (street) \_\_\_\_\_

(city) \_\_\_\_\_ (state) \_\_\_\_\_

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