



Staff Name _____

Address: _____

Physician's Name _____ **Phone Number** _____ **Chart #** (if applicable) _____

MEDICAL HISTORY (to be completed and signed by doctor)

IMMUNIZATIONS DATES

Measles _____	DPT _____
Mumps _____	Polio _____
Rubella _____	HiB _____
Chicken Pox _____	Hep B _____
TB Mantoux _____ *	Tetanus Booster: last received _____
Tine _____	

CURRENT OR PAST HISTORY:

	NO	YES	YEAR	DETAILS		NO	YES	YEAR	DETAILS
Injury	_____	_____	_____	_____	Deformity	_____	_____	_____	_____
Skin	_____	_____	_____	_____	Stomach	_____	_____	_____	_____
Glands	_____	_____	_____	_____	Bowels	_____	_____	_____	_____
Eyes	_____	_____	_____	_____	Hernia	_____	_____	_____	_____
Ears	_____	_____	_____	_____	Kidney	_____	_____	_____	_____
Nose	_____	_____	_____	_____	Bladder	_____	_____	_____	_____
Teeth	_____	_____	_____	_____	wetting	_____	_____	_____	_____
dentures _____				bridge _____	GYN	_____	_____	_____	_____
Chest	_____	_____	_____	_____	Heart :				
Bones	_____	_____	_____	_____	murmur	_____	_____	_____	_____
					other	_____	_____	_____	_____

Behavior _____

Neurologic _____

Contagious _____

Other _____

Date of last physical exam (form should be based on a physical performed within the past 12 months)

Physician's signature _____