EL CAMINO COLLEGE
HEALTH SCIENCES & ATHLETICS DIVISION

RECORD OF MEDICAL HISTORY AND PHYSICAL EXAMINATION

(To be completed by student)

Name: ______________________________________ Date: ___________________

Address: ____

Telephone: ____________________ Social Security No: _________________________

Date of Birth: ______________________ Place of Birth: _____________________________

HEALTH HISTORY:

Check conditions you have had or now have. Show dates on non-chronic conditions.

□ Allergies
□ Anemia
□ Arthritis
□ Asthma
□ Back Pain
□ Bladder Conditions
□ Bronchitis
□ Cancer
□ Chicken Pox
□ Convulsive Disorder
□ Crohn's Disease
□ Diabetes
□ Dizziness
□ Draining Ear
□ Fainting
□ Gall Bladder Disease
□ Headaches (Frequent)
□ Headaches (Migraine)
□ Heart Trouble
□ High Blood Pressure
□ Impairment of Hearing
□ Kidney Trouble
□ Marked Fatigue
□ Nervous Breakdown
□ Other Blood Diseases
□ Palpitation
□ Pneumonia
□ Rheumatic Fever
□ Seizures
□ Smoking Habits
□ Stomach Conditions
□ Thyroid Disease
□ Alcoholism
□ Drug Addiction
□ Ulcers
□ Other

Other: ____

Medications: ____

Surgical Procedures (Dates and Nature): ____

IMMUNIZATIONS: Indicate which vaccinations and immunizations you have had. Give dates.

MMR 1 _____ MMR 2 _____ Influenza _____ Tetanus Booster _____
Hepatitis 1 _____ Hepatitis 2 _____ Hepatitis 3 _____ TB Test ______
Varicella 1 _____ Varicella 2 _____

FAMILY MEDICAL HISTORY

	FATHER	MOTHER	BROTHER	BROTHER	SISTER	SISTER
Name						
Place of Birth						
Occupation						
State of Health						
Age						
If Deceased, Cause of Death						

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LAST NAME: ______________________________ FIRST NAME: _________________________

PHYSICAL EXAMINATION (To be completed by a Physician)

Height: __________ Weight: __________ BP: ________ Pulse: _______ Temperature: _______

Skin:	Ears:	Eyes:
Throat:	Teeth:	Neck:
Chest:	Lungs:	Heart:
Abdomen:	Rectal Exam:	Genitalia:
Hernia:	Pelvic:	

Pregnancy Test:	Back/Spine:
Extremities:	Neurological:

Recommendations: ____

HEARING - OPTIONAL						
	250	500	1000	2000	4000	6000
Right						
Left						
	DATE					

VISION SCREENING		
	Right	Left
Uncorrected		
Corrected		
Color Vision		
Wears	Glasses	Contact Lenses
Date		

Chem Panel Includes URINALYSIS: Date _______________________

This client has been examined and found physical acceptable for a Basic Firefighter Academy.

_____ YES _____ NO

Examining Physician Signature: ____ Date: __________

Physician's Printed Name: ____ Phone: ____________