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

	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: _____