# Oakwood University

## Health and Counseling Services

7000 Adventist Blvd. - Huntsville, AL 35896 - Phone: 256-726-7840 - Fax: 256-726-7471 - Email: ouhs@oakwood.edu

## Medical History & Physical Form

### Student Information

(To be completed by the student)

Last Name: _____ First: _____ Middle: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Country: _____ Home Phone: _____ Cell Phone: _____

Date of Birth (mm/dd/yy): _____ Gender: M ____ F____ SSN: _____

For Emergency Notify: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

### Medical History

(To be completed by the student: check any of the following that you have experienced)

| | | | | |
|---|---|---|---|---|
| ____Anemia | ____ Anxiety | ____Asthma | ____Back pain | ____High Blood Pressure |
| ____Depression | ____ Diabetes | ____Bronchitis | ____Allergies | ____Heart Disease |
| ____Kidney disease | ____ Meningitis | ____Menstrual Problems | ____Cancer | ____Migraine Headaches |
| ____Pneumonia | ____ Seizure | ____Sickle cell | ____Ulcer | ____ADD/ADHD |

List any other illness(es), disabilities or mental health problems you have had or have, and any related treatments:

_____

_____

### Physical Examination

(To be completed by the Physician)

Height: _____ Weight: _____ Blood Pressure: _____ Temp: _____ Pulse: _____ Resp: _____

Vision: R_____ L _____ Corrected: R _____ L _____

| Evaluation | Normal | Abnormal | Comments | | Date | Normal | Abnormal |
|---|---|---|---|---|---|---|---|
| Head | | | | Hct/Hgb | | | |
| Eyes | | | | Glucose | | | |
| Ears | | | | Urinalysis | | | |
| Nose | | | | RPR/Wasserman | | | |
| Throat | | | | | | | |
| Cardiovascular | | | | Medications: | | | |
| Respiratory | | | | | | | |
| Gastrointestinal | | | | | | | |
| Genitourinary | | | | Drug Allergies: | | | |
| Extremities | | | | | | | |
| Neurological | | | | | | | |
| Musculoskeletal | | | | Special Needs: | | | |
| Skin | | | | Other: | | | |
| | | | | | | | |

Print Name or Clinic Stamp: _____ Phone: _____

Address: _____ City: _____ state: _____ Zip: _____

Physician's Signature: _____ Date: _____

***PLEASE COMPLETE AND RETURN PRIOR TO REGISTRATION***