American Institute of Medical Sciences & Education

**AIMS EDUCATION**
4500 New Brunswick Ave. Piscataway, NJ 08854
**WWW.AIMSEDUCATION.EDU**

# Physical Examination Report

## Part I Personal Information (To be completed by a physician)

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____

Family Physician: _____ Phone: _____

## Part II Medical History (To be completed by a physician -Dates need not be exact)

**A. Check disease or illness that you have had:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Measles | | Asthma | | Mumps | | Chicken Pox | |
| Mononucleosis | | Pneumonia | | Rheumatic Fever | | Kidney Disease | |
| Hay Fever | | Hepatitis | | Scarlet Fever | | Cardiac Problems | |

Other serious disease _____

Allergies to Medicines/Latex allergy screen/other: _____

Injuries/ Medical & Surgical History: _____

List medication(s) taken on regular basis: _____

**B. Mandatory Tests and Immunizations (please attach supporting documentation)**

1. Tuberculosis (TB) test (please choose Option A or Option B):
   **Option A:** Two-step PPD skin test (circle results)
   (1)Date Placed_____Date Read_____ Result: NEG / POS (2) Date Placed_____Date Read_____ Result: NEG / POS
   **Option B:** QuantiFERON or T-SPOT TB test (circle result) Date_____Result: NEG / POS
2. Hepatitis B: Vaccine Date 1 _____Date 2 _____ Date 3 _____ *OR* Titer Date_____ Result: _____
3. Measles: Vaccine Date 1 _____Date 2 _____ *OR* Titer Date_____ Result: _____
4. Varicella: Vaccine Date 1 _____Date 2 _____ *OR* Titer Date_____ Result: _____

   If you have not had titer but had Chicken Pox, indicate the date of case: _____
5. Rubella: Date 1 _____Date 2 _____ *OR* Titer Date_____ Result: _____
6. Tdap vaccine: Date: _____
7. Tetanus: Date: _____
8. Seasonal Flu vaccination *(may be required prior to internship)*: Date _____
   *As of 9/26/13, it is now a requirement of the CDC and JCAHO to have this vaccination if you are a healthcare worker directly involved with patients. If, for some reason(s), you do not get this vaccination, you will need supplemental documentation and also your clinical internship site may ask you to sign a waiver and/or wear a protective mask while on duty.
9. Urinalysis for Drug Screening *(Attach Results)*: Date _____

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## Part III Physical Examination (to be completed by a physician)

Height _____ Weight _____ BP _____ Hearing _____ Vision _____ Extremities: _____ Back & Spine: _____

Does the patient's medical history include any communicable diseases? ____ Yes ___ No (If yes, please specify and provide details)

_____

_____

As a student in an allied health training program, he or she may be required to do the following:

1. Provide support to patients (walking, standing, getting out of bed, etc...). Have the ability to lift up to 50 pounds.
2. Communicate with patients, family members, and other healthcare professionals.
3. Provide written documentation.
4. Observe and record visual changes in patients and/or their environment.
5. Operate computers and/or medical equipment that require manual dexterity.

Is he or she physically and emotionally capable of participating in all of the classroom and clinical activities required for an allied health training program? _____ Yes _____ No
Additional Comments (if necessary):

_____

_____

_____

Physician's Name: _____ Signature: _____

Address: _____

Signature: _____ Date: _____