



UNITED TRIBES TECHNICAL COLLEGE
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 Statement of Medical Examination

Name _____ Date of Birth _____

Address _____

If Minor, Name of Parent/Guardian: _____

Past Medical History:

DISEASES/ILLNESS

Disease	When Diagnosed	Treatment	Resolved Chronic Or Freq. Occurrence
Hypertension			
Diabetes			
Heart Disease			
Kidney Disease			
Tuberculosis			
Seizures			
Anxiety/Nervous Reactions			
Ulcers/Gastritis			
Resp. Infections			
Gastroenteritis			
Ear Infections			
Alcoholism			
Musculoskeletal			
Other			

HOSPITALIZATION/SURGERIES

Where	When	Why

B/GYN hx. P. _____ G. _____ Pap _____

Allergies, food sensitivity _____

IMMUNIZATIONS:

DPT. _____

OPV. _____

DT. _____ MMR _____ PPD _____

Current Medications: _____

OVER

Will this person need:

YES

NO

- 1) Follow up for any Med.Surg. Problem? _____
- 2) Glasses? _____
- 3) Dental work? _____
- 4) Immunizations? _____
- 5) Hearing Evaluation? _____

Physical Exam: Wt. _____ Ht. _____ B/P _____ Vision _____
Hearing: Normal _____ Abnormal _____

	Normal	Abnormal	Normal	Abnormal
HEENT			Extremities	
Neck			Musculoskeletal	
Thorac			Spine	
Breast/Axillac			Skin	
Lungs			Genitalia	
Heart			Neurological	
Abd.			Mental Status	

If abnormal, please explain: _____

Lab

Hct _____	UA _____
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Other comments: _____

Service Unit _____ MD Signature _____ Date _____