American CareQuest, Inc
• Medical Education Solutions •
1426 Fillmore Street, Suite 205
San Francisco, CA 94115
☎(415) 885-9100 (415) 885-9107
EDU@AMERICANCAREQUEST.COM

STUDENT'S HEALTH EXAMINATION

Name_____ Date _____
Address _____
SSN _____

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I. Past Medical/Psychological History

Tuberculosis (no) (yes)
Diabetes (no) (yes)
Coronary and Pulmonary (no) (yes)
Hypertension (no) (yes)
Cancer history (no) (yes)
Kidney disease (no) (yes)
Allergies (no) (yes) If Yes, Please state_____
Epilepsy or seizure disorder (no) (yes)
Drug alcohol abuse or addiction (no) (yes)
Psychiatric or Behavioral disorder (no) (yes)
Other_____
Are you now taking any medications? (no) (yes) If yes please state for what_____

Client Signature_____

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II. Examiner please complete following:

Mandatory Immunization. Exact titer must be given as requested

PPD (Mantoux)_____Date_____Result_____Date_____
2nd STEP PPD_____Date_____Result_____Date_____
Rubella titer_____ ( ) IMMUNE ( ) NOT IMMUNE VACINE(if needed)_____
Rubeolla titer_____ ( ) IMMUNE ( ) NOT IMMUNE VACINE(if needed)_____
Measles or recall having had measles (if borne before 1957)_____

HEPATITES B ( ) IMMUNE ( ) REFUSAL ( ) IMMUNIZATION CONTRAINDICATED

***CHEST X-RAY MANDATORY IF PPD POSITIVE

PHYSICIAN SIGNATURE_____ DATE: _____

PHISICIAN NAME (PRINT)_____

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Patient Name_____

III. REVIEW OF SYSTEMS BY EXAMINER

Head/Neck_____

ENT_____

Respiratory_____

Cardiovascular_____

Abdomen-Gastrointestinal_____

Gynecology/Urology_____

Muscular-Skeleton_____

Neuro_____

Endocrine_____

Skin_____

Infectious disease_____

Height_____ Weight_____

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IV. MEDICAL EXAMINER:

I hereby certify that the above named patient does not have any limitation for employment in the health care field, free from sighs or symptoms of infectious disease, and contact with patients and other stuff. There is no health impairment present that is of potential risk to the employee, patient, family, or other employees or that may interfere with the performance of duties.

PHYSICIAN SIGNATURE_____ DATE: _____

PHYSICIAN NAME (PRINT)_____

ADDRESS_____

PHONE_____