UAB SH&W PHYSICAL EXAMINATION (***Please print in black ink***) To be completed and **signed** by physician or clinician. A physical examination is required for all clinical students within 1 year prior to matriculation.

You may schedule a physical exam at Student Health & Wellness if you do not have a physician. Schedule an appointment through your patient portal or call 205-934-3580 and ask our receptionist for details.

Last Name First Name Middle	Date of Birth (mm/dd/yyyy)	BlazerID@uab.edu
Permanent Address City State Zip Code		Area Code/Phone Number

Height _____ Weight _____ TPR _____/_____/_____ BP _____/_____

Vision: Corrected Right 20/_____ Left 20/_____

Uncorrected Right 20/_____ Left 20/_____

Color Vision _____

Are there abnormalities? If so, describe full	WNL	ABN	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Musculoskeletal			
7. Metabolic/Endocrine			
8. Neuropsychiatric			
9. Skin			
Other			

A. Is there loss or seriously impaired function of any organs? ____No ____Yes
Explain _____

B. Recommendation for physical activity (physical education, intramurals, etc.) ____Unlimited ____Limited
Explain _____

Signature of Physician/Physician Assistant/Nurse Practitioner Date

Print Name of Physician/Physician Assistant/Nurse Practitioner Date

Office Address/Stamp Area Code/Phone Number

UAB Student Health and Wellness
Health History Form
Learning Resource Center
1714 9th Avenue South, 3rd Floor
Birmingham, Alabama 35294-1270
(205) 934-3580

Please save this form and upload it to your patient portal for your medical clearance.

Entering Semester: ☐ Fall ☐ Spring ☐ Summer ● Year_____ ● UAB Student No. __B_____

General Information

Full Name:_____ Gender: ☐ Male ☐ Female
Last First MI ☐ Transgendered ☐ Transitional

Date of Birth: *Month*: _____ *Day*: _____ *Year*: _____

School: _____ Program or Major Code:_____
CAS, Med, Dent, SHP, Nurs. etc. Education, History, Physics, Biology, etc.

Current Email address: _____ Blazer ID: _____

Are you an International Student or Scholar? ☐ Yes ☐No If Yes, which country?_____

Telephone number: _____ _____ Height: _____ Weight:_____
Home *Cell*

Local Address: _____

Permanent Address _____

Primary emergency contact: _____Telephone number: _____ Relationship: _____

Secondary emergency contact: _____Telephone number: _____Relationship: _____

Personal Health History

Medical Conditions

Please list any surgeries, asthma, diabetes, ADHD, injuries, hospitalizations, etc.

Name	Description	Year

Medications

Please list prescription, non-prescription, vitamins, birth control, etc.

Name	Description	Dosage

Food/Medicine Allergies

Please list penicillin, codeine, insect bites, antibiotics, specific food or chemical, etc.

Name	Description	Reaction

Family & Personal Health History (to be completed by the student)
Has any person, related by blood, had any of the following?

Yes	No		Relationship
		High Blood Pressure	
		Stroke	
		Cancer	
		Heart attack before age 55	
		Diabetes	
		Glaucoma	

Yes	No		Relationship
		Cholesterol or blood fat disorder	
		Blood clotting disorder	
		Psychiatric	
		Suicide	
		Alcohol/drug problems	

Have ever had or now have: (please check at right of each item and if yes, indicate year of first occurrence)

Yes	No	Symptom	Year
		High Blood Pressure	
		Rheumatic fever	
		Heart trouble	
		Pain/pressure in chest	
		Shortness of breath	
		Asthma	
		Pneumonia	
		Chronic cough	
		Tuberculosis	
		Tumor/cancer (specify)	
		Malaria	
		Thyroid trouble	
		Serious skin disease	
		Hearing loss	
		Sexually transmitted disease	
		Severe menstrual cramps	
		Irregular periods	
		Frequent vomiting	
		Gall bladder or gallstones	
		Jaundice or Hepatitis	
		Rectal disease	
		Severe/recurrent abdominal pain	
		Sinusitis	
		Hernia	
		Chicken pox	
		Anemia/Sickle Cell Anemia	
		Eye trouble besides glasses	
		Bone, joint, other deformity	
		Shoulder dislocation	
		Knee problems	
		Recurrent back pain	
		Neck injury	
		Diabetes	

Yes	No	Symptom	Year
		Mononucleosis	
		Hay fever	
		Head/neck radiation	
		Arthritis	
		Concussion	
		Frequent/severe headache	
		Dizziness/fainting spells	
		Severe head injury	
		Paralysis	
		Epilepsy/seizures	
		Blood transfusion	
		Protein in blood or urine	
		Ulcer (duodenal/stomach)	
		Intestinal trouble	
		Pilonidal cyst	
		Allergy injection therapy	
		Back injury	
		Broken bones	
		Kidney infection	
		Bladder infection	
		Kidney stone	
Mental Health History			
		Sleep problems	
		Self-injurious Behavior	
		Depression/bipolar	
		Anxiety/panic	
		LD/ADD/ADHD	
		Eating Disorder	
		Obsessive compulsive	
		Self-induced vomiting	
Substance Use History			
		Alcohol/drug problem	
		Smoke 1+ pack cigs/week	

UAB Student Health & Wellness Immunization Form

Clinical Domestic Students

NAME: _____ DATE OF BIRTH: (mm/dd/yyyy): _____

ADDRESS: _____ PHONE: _____

PROGRAM OF STUDY: _____ BLAZERID:_____@UAB.EDU

IMMUNIZATION HISTORY MUST BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER

***Copies of your original immunization records are acceptable in place of this form. Please submit completed form or immunization records directly to your UAB SH&W Patient Portal.**

1. **MMR**- Measles, Mumps, and Rubella: All students must satisfy this requirement, either by two vaccine doses against each of the three diseases or laboratory evidence of immunity to all three diseases.

EITHER

Two doses of MMR vaccine: Date: _____/_____/_____
Date: _____/_____/_____

OR

Two doses of each vaccine component:
Measles Date: _____/_____/_____ Date: _____/_____/_____
Mumps Date: _____/_____/_____ Date: _____/_____/_____
Rubella Date: _____/_____/_____ Date: _____/_____/_____

OR

Laboratory evidence of immunity to all three diseases:
Measles Date: _____/_____/_____ Result: _____
Mumps Date: _____/_____/_____ Result: _____
Rubella Date: _____/_____/_____ Result: _____

*If any laboratory titers are non-immune, 2 repeat vaccines are required. Date: _____/_____/_____ Date: _____/_____/_____

2. **Tdap**- Tetanus, Diphtheria, Acellular Pertussis: All students must have had one dose of the adult Tdap given 2006 or later. If the last adult Tdap is greater than 10 years old, a Td booster is required.

Tdap Date: _____/_____/_____
Td Date: _____/_____/_____

3. **Hepatitis B Series**: All students must have a series of three Hepatitis B vaccinations (initial dose, dose two at 1 month, dose three at 6 months). A post-vaccine surface antibody titer (to demonstrate immunity) is required one month after 3rd vaccine dose.

Dose 1 Date: _____/_____/_____ Dose 2 Date: _____/_____/_____ Dose 3 Date: _____/_____/_____
Hep B surface antibody titer: Reactive: _____ Non-Reactive: _____ Date: _____/_____/_____

*<u>If Hep B surface antibody is non-reactive, repeat series and post-vaccine surface antibody titer are required</u>.
Dose 1 Date: _____/_____/_____ Dose 2 Date: _____/_____/_____ Dose 3 Date: _____/_____/_____
Hep B surface antibody titer: Reactive: _____ Non-Reactive: _____ Date: _____/_____/_____

*If repeat Hep B surface antibody is non-reactive, Hep B surface antigen is required to rule out acute or chronic Hep B infection.
Hep B surface antigen titer: Positive: _____ Negative: _____ Date: _____/_____/_____

**If Hep B surface antigen is positive, visit with SH&W provider is required for additional testing. If negative, student will be considered a non-responder.

4. **Varicella** (chickenpox or shingles): All students must have documented history of Varicella, a positive Varicella antibody titer, or two doses of Varicella vaccines given at least 28 days apart.

EITHER

History of Varicella (chickenpox or shingles): Yes: _____ No: _____ Date: _____/_____/_____

OR

Varicella antibody titer Positive: _____ Negative: _____ Date: _____/_____/_____

OR

Varicella vaccination Dose 1: _____/_____/_____ Dose 2: _____/_____/_____

*If Varicella antibody titer is negative or equivocal, two repeat vaccinations are required.

Varicella vaccination Dose 1: _____/_____/_____ Dose 2: _____/_____/_____

5. **Meningococcal**: All students 21 and younger are required to show documentation of a meningitis vaccine given on/after their 16th birthday. Students age 22 and older are exempt. Date: _____/_____/_____

6. **Tuberculosis**: All clinical students must meet UAB's Tuberculosis screening requirement. If no history of positive Tb skin test, two separate skin tests or one IGRA blood test are required upon matriculation. Skin tests must be placed at least one week apart.

EITHER

a. Tuberculin Skin Test (PPD) within 12 months prior to matriculation:

Date Placed: _____/_____/_____ Date Read: _____/_____/_____ Result (mm): _____ Positive: _____ Negative: _____

b. Tuberculin Skin Test (PPD) within 3 months prior to matriculation:

Date Placed: _____/_____/_____ Date Read: _____/_____/_____ Result (mm): _____ Positive: _____ Negative: _____

OR

a. IGRA (Tspot or Quantiferon TB Gold) blood test and UAB TB Questionnaire within 3 months prior to matriculation:

Date: _____/_____/_____ Positive: _____ Negative: _____

b. UAB TB Questionnaire

*If positive skin test or IGRA result, Chest X-Ray within 3 months prior to matriculation and UAB TB Questionnaire required.

a. Chest X-Ray Date: _____/_____/_____ Normal: _____ Abnormal: _____ (*Please attach results)

b. UAB High Risk TB Questionnaire

c. Have you been treated with anti-tubercular drugs? Yes: _____ No: _____

If yes, type of treatment: _____ Length of Treatment: _____ *Please attach supporting documentation.

Verification of the above Student Immunization Record and Tuberculosis Screening by Health Care Provider:

Verified by: _____ Title: _____

Address: _____

Phone: _____

Signature: _____ Date: _____/_____/_____