

**RENTON TECHNICAL COLLEGE  
HEALTH RECORD  
FOR PARTICIPATION IN  
ALLIED HEALTH  
DEPARTMENT  
PROGRAMS**

**FORM E**

DATE: \_\_\_\_\_

PROGRAM: \_\_\_\_\_

NAME: \_\_\_\_\_

STUDENT NUMBER:  
\_\_\_\_\_

DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_ AGE: \_\_\_\_\_

This evaluation is only to determine readiness for participation in an allied health program. It should not be used as a substitute for regular health maintenance examinations. The health history and physical examination record sections must both be completed prior to entry into the allied health program. Please have your completed form for your student record.

**HEALTH HISTORY:**

To be completed by student

	YES	NO
1. Have you ever had an illness that:	___	___
a. Required you to stay in the hospital?	___	___
b. Lasted longer than a week?	___	___
c. Is related to allergies? (i.e. hay fever, hives, asthma, insect stings)	___	___
d. Required an operation?	___	___
e. Is chronic? (asthma, diabetes, anemia, epilepsy)	___	___
2. Have you ever had an injury that:		
Caused you to miss more than three consecutive days of participation in usual activities this past year?	___	___
If yes, please indicate:		
Site of injury _____		
Type of injury _____		
a. Required you to go to an emergency room or to see a doctor?	___	___
b. Required to stay in the hospital?	___	___
c. Required x-rays?	___	___
d. Required an operation?	___	___
3. Do you take any medication or pills?	___	___
List all medications you are presently taking and what condition the medicine is for?		
a. _____		
b. _____		
c. _____		
4. Have any members of your family under the age of 50 had a heart attack, heart problems, or died unexpectedly?	___	___
5. Have you ever:		
a. Been dizzy or passed out during or after exercise?	___	___
b. Been unconscious or had a concussion?	___	___
6. Are you unable to run ½ mile (2 times around the track) without stopping?	___	___
7. Do you have any problems standing for long periods? Or walking? Ability to lift 50 lbs or more	___	___
8. Do you wear glasses or contacts?	___	___
9. Have you ever had a heart murmur, high blood pressure, or a heart abnormality?	___	___
10. Do you have any allergies to any medicine? If yes, what? _____	___	___
11. Do you have any skin conditions? Particularly arms and/or hands	___	___
12. Are you missing a kidney?	___	___
13. Any psychological illness? Are you currently being treated? If so, what medication? _____	___	___
14. <b>For Women:</b>		
a. At what age did you experience your first menstrual period? _____		
b. In the last year, what is the longest time you have gone between periods? _____		
15. Are you worried about any problem or condition at this time? If yes, please explain: _____ _____	___	___
16. Year of Last Complete Physical? _____		
17. Is there a family history of: Diabetes, Polycentric Kidneys, Congenital Heart Disease, Hypertension, Breast Cancer, GI Cancer, etc.? Who? _____ _____ _____		

I hereby state that, to the best of my knowledge, my answers to the physical exam history are correct.

Date: \_\_\_\_\_ Student Signature: \_\_\_\_\_

Renton Technical College  
Allied Health Department

PRINT YOUR NAME: \_\_\_\_\_

**STUDENTS: DO NOT WRITE BELOW THIS LINE  
FOR PHYSICIAN / NURSE PRACTITIONER or PA ONLY** \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Percent Body Fat (optional) \_\_\_\_\_

	Normal	Abnormal Findings
Eyes		
Ears, Nose, Throat		
Mouth and Teeth		
Neck		
Cardiovascular		
Chest and lungs		
Abdomen		
Skin		
Genitalia – Hernia (male)		
Musculoskeletal: ROM, Strength		
A. Neck		
B. Spine		
C. Shoulders		
D. Arms/Hands		
E. Hips		
F. Thighs		
G. Knees		
H. Ankles		
I. Feet		
Neuromuscular		

Participation recommendations: Full participation \_\_\_\_\_

1. No participation in \_\_\_\_\_

2. Limited participation in \_\_\_\_\_

Health Care Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Telephone Number \_\_\_\_\_ Address \_\_\_\_\_