Penn State New Kensington
Radiological Sciences Program Physical Examination

Personal Information (Student information)

First Name: _____ Middle Name: _____ Last Name: _____

Sex: _____ Date of Birth (mm/dd/yyyy): _____

Address: _____

City: _____ State: _____ Zip Code: _____ Country: _____

Phone #: _____ Social Security #:_____

Emergency Contact Information (Person to contact in an emergency)

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Country: _____

Phone #: _____

Medical Questions

1. Any present medical conditions or symptoms?
   - ☐ No
   - ☐ Yes (Please explain)

_____

_____

_____

_____

2. List injuries, operations, serious illnesses and dates:

_____

_____

_____

_____

3. Are you presently taking any medications?
   - ☐ No
   - ☐ Yes (Please list and explain)

_____

_____

_____

_____

4. Date of last medical examination: _____
5. Date of last dental examination: _____
6. Allergies (including those to medications) and reactions:

_____

_____

_____

_____

Family History

Yes	No	Item
		Epilepsy
		Cancer
		Heart Disease
		High Blood Pressure
		Stroke
		Kidney Disease
		Tuberculosis
		Diabetes
		Allergy
		Mental Illness

Physical Examination

Height: _____

Weight: _____

Temperature: _____

Pulse: _____

Respirations: _____

Blood Pressure: _____

Hearing:

Right_____ Left_____

Vision:

Without/With Correction Right 20/____ Left 20/____

Color Blindness

☐ No

☐ Yes

Physical Exam

Physical Exam	Normal	Abnormal Findings/Comments
Nutrition		
Development		
Eyes		
Ears		
Nose		
Throat		
Teeth and Gums		
Thyroid Gland and Neck		
Thorax		
Lungs		
Heart		
Breast		
Peripheral Pulses		
Abdomen		
Hernia		
Genitalia (Males Only)		
Rectal (Males only if indicated)		
Spine and Back		
Extremities		
Neurological		
Skin		

Summary, Remarks, and/or Recommendations

_____

_____

_____

_____

Immunization Record

All students enrolled in the Penn State New Kensington Radiological Sciences Program must provide proof of the following before completing any clinical rotations at any of the recognized clinical sites.

Two-Step PPD testing (must be completed within the past six months)

TB Skin Test (2 step PPD) Date #1_____ Result #1 _____ mm. pos _____ neg _____

Date #2_____ Result #2 _____ mm. pos _____ neg _____

If >5mm indurations, date and results of last chest X-ray (must be within one year) _____

If indicated, INH Therapy: Yes / No

If yes: Date Began _____ Date Completed _____

Please provide documentation of one of the following: (Must be within the past 10 yrs.)

Tetanus, Td Date:_____

OR

DTap Date:_____

OR

Tdap Date:_____

Please provide documentation of the following:

Measles (2) Date:_____ Date:_____

OR Titer Date:_____ Pos. _____ Neg. _____

Mumps (2) Date:_____ Date:_____

OR Titer Date:_____ Pos. _____ Neg. _____

Rubella (1) Date:_____

OR Titer Date:_____ Pos. _____ Neg. _____

MMR (2) Date:_____ Date:_____

OR Titer Date:_____ Pos. _____ Neg. _____

OR

Immune if born prior to 1957 Yes:_____ BD:_____

Please provide documentation of the following:

Varicella (Chickenpox) (2) Date:_____ Date:_____

OR

Varicella Titer Date:_____ Pos. _____ Neg. _____

Please provide documentation of the following:

Hepatitis C Titer Date:_____ Pos._____ Neg._____

Course of treatment (type & date) Date:_____

Please provide documentation of the following: (must include dates of series and titer)

Hepatitis B Series (3) Date:#1_____

Date:#2_____

Date :#3_____

Hepatitis B Titer Date:_____ Pos._____ Neg._____
(titer results must be included)

Signature of Physician or CRNP:_____ Date:_____

Address: _____

Phone: _____

All students must complete a routine drug screening as well as a criminal history record (background check) to include PA criminal history record, Act 33/34 and 73 clearances. It is the student's responsibility to keep all original forms and upload to Castlebranch the student record manager. Upon request, the student must present any original form to clinical affiliate personnel authorized to view the information.

Routine drug screening must be completed during orientation to the program. Please do not complete drug screening until assigned. You may incur additional expenses if you do so. Information for Castlebranch can be found on the program website.

The information provided on this form is true and accurate and when asked will provide proper documentation for verification of any/all information recorded. Any student providing false, misleading or inaccurate information may be dismissed from the program. I understand the information recorded may be released to the clinical agencies while I am participating in undergraduate Radiological Science education. I also understand the information contained on this form may be used for peer review for accreditation purposes.

_____

Signature of Student Date

Revised:9-22-08/dm, 1-23-09/dm, 8-09/dm, 9-10dm, 9-12dm,12-12dm, 4-14dm,8-15dm,5-16dm.