COLUMBIA STATE COMMUNITY COLLEGE

Radiology Physical Exam Form
Health Sciences
Phone: (931) 540-2849 Fax: (931) 560-4103
Email: healthrecords@columbiastate.edu

Please Print
Date of Physical Exam: _____ Name of Student: _____

Phone: _____ Date of Birth: _____ SS#: _____ Sex: M F

Age: _____ Height: _____ Weight: _____ BP: _____ Pulse: _____ Temperature: _____

Urinalysis: Protein: _____ Leukocytes: _____ Glucose: _____ Blood: _____ Bilirubin: _____

CBC:_____ **Eyes:** _____ Visual Acuity R: _____ L: _____ Color Blindness: Y_____ N_____

Ears: _____ Hearing: _____ R: _____ L: _____ **Nose:** _____ **Oropharynx**: _____

General conditions of teeth (caries, dentures, braces, implants) : _____

Skin:_____ **Breasts:**_____ **Spine:**_____

Musculo-skeletal system (joint instability, inflammatory conditions, surgical repairs)**:**_____

Cardiovascular:_____ **Respiratory:**_____ **Abdomen:**_____
(pain, scars, masses, hernia)
Genito-urinary systyem:_____ **Hemorrhoids:**_____ **Varicosities:**_____

Is this student in good condition capable of completing clinical rotations in a healthcare setting? Y_____ N_____

Reason he/she is not:_____

Physician's recommendations for further testing or comments: _____

TB SKIN TEST #1

_____	_____	_____
Date Given	Location	Health Care Provider Signature
_____	Positive Negative _____mm	_____
Date Read	Circle One Size	Health Care Provider Signature

TB SKIN TEST #2

_____	_____	_____
Date Given	Location	Health Care Provider Signature
_____	Positive Negative _____mm	_____
Date Read	Circle One Size	Health Care Provider Signature

Chest X-ray only if TB Positive

_____	_____	_____
Date of X-ray	Results	Health Care Provider Signature

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NOTE: Attach all Lab and Radiology Reports to this form. The student will be required to provide them.

Please provide proof of MMR, Varicella, and Hepatitis B immunization either by Titer/IGG lab or by immunization records.
Proof of Immunizations is required if any titers return Not Immune, Equivocal, or Non-Reactive.

MMR (required)
Dates of 2 MMR Immunizations: Date #1_____ Date #2_____

OR

Date of Titer/IGG for Rubeola: _____ Mumps: _____ Rubella: _____

Result of Titer/IGG for Rubeola: _____ Mumps: _____ Rubella: _____

VARICELLA ZOSTER (required)
Dates of 2 Varicella Zoster Immunizations: Date #1_____ Date #2_____

Have you ever had chicken pox? If YES, provide date: _____ NO: _____

OR

Date of Titer/IGG for Varicella Zoster: _____ Result of Titer/IGG for Varicella Zoster: _____

HEPATITIS B (required)
Date of Hepatitis B series (received): #1_____ #2_____ #3_____

AND

Date of Hepatitis B Surface Antibody: _____ Result of Hepatitis B Surface Antibody: _____
(After completion of series) **(Lab report must be attached)**

Please use results from Hepatitis B Surface Antibody to complete the Hepatitis Vaccine Recombivax HB Info Form (aka HEP B Form).

INFLUENZA (required for Fall/Spring students)
Date of Seasonal Influenza Immunizations (due Sept 24th for Fall students, due NOW for Spring Students): _____

TDAP (required)
Date of (Tdap): _____ ***You must have a booster if your vaccination is over ten years old.***

_____, M.D. _____
Physician's /Provider's Signature Date

_____, M.D. _____
Print or type Physician's/Provider's Name Physician's/Providers Address

PLEASE sign off on any readings, immunizations, titers, after original signature. _____
Signature Date