Macomb Community College
Public Service Institute
EMT/Paramedic Programs
44575 Garfield Road, A-126
Clinton Township, MI 48038-1139
586.286.2189

HEALTH HISTORY (To be filled out by the student)

Student: ☐ Male ☐ Female

NAME		
HOME ADDRESS		
CITY	STATE	ZIP
HOME PHONE	DATE OF BIRTH	

Person to notify in an emergency:

NAME		
HOME ADDRESS		
CITY	STATE	ZIP
HOME PHONE	RELATIONSHIP	

Personal History

1. Have you ever had, or do you now have, any of the following:

	YES	NO
High Blood Pressure	☐	☐
Rheumatism/Arthritis	☐	☐
AIDS	☐	☐
HIV Positive	☐	☐
Anemia	☐	☐
Alcoholism	☐	☐
Drug Dependency	☐	☐
Rheumatic Fever or Chorea	☐	☐
Heart Disease	☐	☐
Tuberculosis	☐	☐
Recurrent Headaches	☐	☐
Discharging Ear	☐	☐
Chronic Appendicitis	☐	☐
Diabetes	☐	☐
Hernia	☐	☐
Asthma	☐	☐
Convulsions, "Black-Out," or Seizures	☐	☐
Mental or Nervous Disorder	☐	☐
Back Injury or Problems	☐	☐
Sensitivity to Any Medications	☐	☐
OTHER	☐	☐

2. Are you now receiving treatment for any of the above?
☐ Yes ☐ No
If Yes, please explain: _____

3. Do you have any physical impairment, such as paralysis, loss of vision, impaired hearing, impaired speech, etc.?
☐ Yes ☐ No
If Yes, explain: _____

4. Are you taking any medications regularly?
☐ Yes ☐ No
If Yes, explain: _____

5. Dates of significant injuries or operations which you have had:

INJURY/OPERATION	DATE

If none, check here ☐

6. Have you ever been advised against normal physical exercise? ☐ Yes ☐ No
If yes, explain, giving advisor, date of advice, and reason:

PHYSICAL EXAM (To be completed by the physician)

(This physical examination will be at the student's expense)

Height: _____

Weight: _____

B.P.: _____

Pulse: _____

	NORMAL	ABNORMAL
Cardio-Vascular	☐	☐
Respiratory	☐	☐
Digestive	☐	☐
Nose and Throat	☐	☐
Ears (Hearing)	☐	☐
Eyes (Vision)	☐	☐
Nervous System	☐	☐
Bones and Joint	☐	☐

Describe abnormalities briefly:

_____

_____

_____

_____

Is this student presently under medical therapy? ☐ Yes ☐ No

If Yes, please explain: _____

_____

_____

Is this student capable of normal physical exercise?

☐ Yes ☐ No

If No, please explain: _____

_____

_____

Is this student presently under medical, neurological or psychiatric treatment? ☐ Yes ☐ No

If Yes, please explain: _____

_____

_____

Does this student have a history of Hepatitis B? ☐ Yes ☐ No

Is this student a carrier? ☐ Yes ☐ No

Are there any physiological and/or psychological limitations that would restrict this individual's participation in the EMT and/or Paramedic program? ☐ Yes ☐ No

If Yes, please explain: _____

_____

_____

_____

_____

(Student must submit copies of lab tests and results for following diagnostic tests and immunizations)

Diagnostic Tests (To be completed by the physician)

			DATE COMPLETED	COMMENTS
Tetanus (Received within the last 10 years)				
TB Test*	☐ Positive	☐ Negative		
Chest X-Ray*	(only if positive TB Test)			
*Must be within one year of administrative practicum start date.				
Titers* must be drawn for:				
Rubella	☐ Positive	☐ Negative		
Rubeola	☐ Positive	☐ Negative		
Mumps	☐ Positive	☐ Negative		
Varicella	☐ Positive	☐ Negative		
Hepatitis B	☐ Positive	☐ Negative		

*Titers are highly recommended but not required if student has immunization records.

DATE	DATE	DATE
1st Hepatitis B_____	2nd Hepatitis B_____	3rd Hepatitis B_____

MMR (Mumps, Measles, Rubeola Date_____

Varicella Date_____ ☐ **5 Panel Drug Screen**

_____

SIGNATURE OF PHYSICIAN DEGREE DATE

_____

PLEASE **PRINT** NAME