COLLEGE OF MICRONESIA – FSM
P.O. Box 159, Kolonia, Pohnpei FSM 96941
Phone: (691) 320-2480 Fax: (691) 320-2479 Website: www.comfsm.fm

Student Health Services

HEALTH EXAMINATION FORM

1 Name (Last Name, First Name, Middle Name)		**2** Date
3 Marital Status ☐ Single ☐ Married Name of Spouse: ☐ Widow _____	4 Sex ☐ Female ☐ Male	5 Date of Birth (MM/DD/YY)
6 Mailing Address (P.O. Box, City, State, Country, Zip Code)	7 Phone Number	8 Email Address

EMERGENCY CONTACT INFORMATION

9 Name of Next of Kin (Last, First, Middle Initial)	10 Relationship	11 Next of Kin Phone Number
12 Next of Kin Mailing Address (P.O. Box, City, State, Country, Zip Code)	13 Next of Kin Citizenship ☐ Micronesian ☐ Others, specify _____	

LABORATORY

BLOOD		URINALYSIS		STOOL FOR O & P		DATE RX	BACTERIOLOGY	
Kahn/VDRL		Sugar		Ascaris			Grainstain for Gonococcus	
Hemoglobin		Albumen		Amoeba			Pregnancy Test (+/ -)	
Hematocrit		Micro		Hookworm				
Type/RH		Genitourinary Exam					Have you any physical disability? If yes, please explain:	
Filariasis		ECG Results						

IMMUNIZATIONS		Height	Weight	Pulse	Blood Pressure
	DATE	Vision (Left)	Vision (Right)	Hearing (Left)	Hearing (Right)
Measles					
Mumps					
Rubella					
Polio (Oral)					
DPT or DT					
BCG					
PPD Test					
Date Read					
Result (mm)					
X-Ray if PPD+					

FAMILY HISTORY
Have any of your family members or relatives had any of the following?

Have they had…	Yes	No	Relationship	Have they had…	Yes	No	Relationship
Tuberculosis				Heart Disease			
Leprosy				Kidney Disease			
Diabetes				Hepatitis			
High Blood Pressure				Stomach Ailment			
Arthritis				Asthma, Hay Fever			
Epilepsy				Heart Attack			
Convulsions				Use of Pacemaker			
Other:				Other:			

PERSONAL HISTORY
Please Indicate Yes or NO for all questions. Make sure appropriate comments are given in the space provided.

Have you had	Yes	No	Have you ever had	Yes	No	Do you frequently have	Yes	No	Comments
Rheumatic Fever			Tuberculosis			Insomnia (Can't Sleep)			
Measles			Amoebiasis			Anxiety, Worry			
German Measles			Filariasis			Depression			
Mumps			Ascariasis			Nervousness			
Polio			Hookwork			Stomach Trouble			
Hepatitis			Pain in the chest			Diarrhea			
Chicken Pox			High Blood Pressure			Dizzines, Faintness			
Cholera			Diabetes			Palpitation			
Leprosy			Kidney Disease			Headaches			
Venereal Disease			Epilepsy			Cold, Sore Throat			
Any Surgery			**List below all medical treatments and/or medications that you are currently undergoing and the reasons for them:**						
Tumor or Cancer									
Allergy									
Hay Fever									
Asthma									

IMPORTANT: PREGNANT WOMEN WILL NOT BE ADMITTED AS RESIDENT STUDENTS IN THE COM-FSM RESIDENCE HALLS

GENERAL QUESTIONS	YES	NO	COMMENTS
1. Has a doctor ever denied or restricted your participation in sports for any reason?			
2. Have you ever spent the night in the hospital?			
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**	**COMMENTS**
3. Have you ever passed out or nearly passed our DURING or AFTER exercise?			
4. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			
5. Does your heart ever race or skip beats (irregular beats) during exercise?			
6. Has a doctor ever ordered a test for your heart? (ECG/EKG, echocardiogram)			
7. Do you get lightheaded or feel more short of breath than expected during exercise?			
8. Have you ever had an unexplained seizure?			
BONE & JOINT QUESTIONS ABOUT YOU	**YES**	**NO**	**COMMENTS**
9. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss practice or game?			
10. Have you ever had any broken or fractured bones or dislocated joints?			
11. Have you ever had a stress fracture?			
12. Do you regularly use a brace, orthotics, or other assistive devices?			
13. Do you have a bone, muscle, or joint injury that bothers you?			
14. Do any of your joints become painful, swollen, feel warm, or look red?			
MEDICAL QUESTIONS	**YES**	**NO**	**COMMENTS**
15. Have you ever tested positive for any sexually transmitted diseases or infections?			
16. Do you chew tobacco/ betelnut, drink, or smoke?			
17. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
18. Have you ever had an inhaler or taken asthma medicine?			
19. Do you have groin pain or a painful bulge or hernia in the groin area?			
20. Have you had infectious mononucleosis within the last month?			
21. Do you have rashes, pressure sores, or other skin problems?			
22. Have you had a herpes or MRSA skin infection?			
23. Have you ever had a head injury or concussion?			
24. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?			
25. Do you have headaches with exercise?			
26. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?			
27. Have you ever become ill while exercising in the heat?			
28. Do you get frequent muscle cramps when exercising?			
29. Have you had any eye injuries?			
30. Do you worry about your weight?			
31. Are you trying to or has anyone recommended that you gain or lose weight?			
32. Are you on a special diet or do you avoid certain types of foods?			
33. Have you ever had an eating disorder?			
34. Do you have any concerns that you would like to discuss with your doctor?			
FEMALES ONLY	**YES**	**NO**	**COMMENTS**
35. Have you ever had a menstrual period?			
36. When was your last menstrual period?			
37. How old were you when you had your first menstrual period?			
38. How many periods have you had in the last 12 months?			
39. Are your periods regular each month? Do they come at the same time each month?			
40. Have you ever been pregnant?			

SUMMARY	
My examination revealed:	CHECK ONE
CLEARED FOR ALL SPORTS WITHOUT RESTRICTION	
CLEARED FOR ALL SPORTS WITHOUT RESTRICTION WITH FURTHER EVALUATION OR TREATMENT FOR:	
NOT CLEARED: Pending Further Evaluation	
NOT CLEARED: For Any Sports	
NOT CLEARED: For Certain Sports Reason:	
RECOMMENDATIONS:	

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and or participate in sport(s) outlined above. A copy of the physical exam is on record in my office and can be made available upon request. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parent/ guardian for minors).

Physician's Signature (Over Printed Name) Date

Address Phone Number

Student's Signature (Over Printed Name) Date

IF THE STUDENT IS UNDER THE AGE OF 18, A PARENT/ GUARDIAN SIGNATURE IS REQUIRED BELOW

Parent/ Guardian Signature (Over Printed Name) Date