

March 27, 2009

Dear Entering SN Student,

The attached health documentation is required as per University Policy and is for your protection as well as the protection of patients and staff. Please be advised that **you will not** be able to use your UMDNJ student health insurance to cover these requirements as your insurance will not be activated until you are matriculated.

The documentation must be completed within the following timeframe and is a requirement for matriculation:

Now:

- Read through all forms in this packet
- Schedule an appointment with your healthcare provider for a complete history and physical and completion of immunization forms
- Review the “Student Immunization & Health Requirements Policy”
http://www.umdj.edu/oppmweb/university_policies/student_affairs/PDF/00-01-25-40_00.pdf
- Review the Meningococcal Vaccine document enclosed
- Complete and Return Meningococcal Meningitis Response Form
- If you are planning on applying for on-campus residence, you will need to have received a meningococcal vaccination

Due 2 months before start:

- Recently completed history and physical examination forms
- Documentation of all required immunizations on the enclosed form (no other forms will be accepted)
- Copies of any required lab reports (titers, chest-x-ray if necessary)
- The “Hepatitis B Record” (*If you have not had the Hepatitis B immunization series (and the subsequent blood titer to confirm immunity), it may take substantial time to complete. **Please begin immediately***)

Due 1 month before start:

- A “two step” PPD. *This consists of two PPD tests placed approx. 1-3 weeks apart. Each test must be read 48-72 hours after placement.* You may submit documentation of PPD (in millimeters of induration) and additional Hep B vaccines on your healthcare provider's letterhead or prescription pad. **All other immunizations and lab work must be documented on our forms.**

Please make sure to have your health care provider complete, sign and date all forms. Bring the attached **checklist** to your provider so that the appropriate tests are performed. This may help to avoid unnecessary costs to you, as any incurred costs related to the above requirements are your responsibility.

If you have any questions or require additional information please contact the Employee and Student Health at: **(856) 566-6825.**

Please mail or FAX the completed forms to:

**University Doctor's Pavilion
Employee and Student Health
42 East Laurel Road
Suite 2100
Stratford, NJ 08084
Fax: 856-566-6188**

Sincerely
Carman Ciervo, DO

*****URGENT! These requirements can take substantial time to complete, so please obtain immunizations and required tests right away.**

The enclosed forms must be completed by you and your health care provider and returned to the Student Health and Wellness Center eight weeks prior to the beginning of the semester you enroll. Please contact us if you have any questions or concerns. Our office number is 973-972-7687.

Health Care Provider: Immunization Check List

- A completed history and physical, **that must be dated, signed and stamped by the student's primary care provider, on our forms.**

- Tdap (tetanus/diphtheria/acellular pertussis) (Adacel) students must receive one dose of Tdap if two or more years have passed since the last Td booster dose or since the primary DPT series

- 2 doses of the Measles vaccine, or a Rubeola IgG titer showing positive immunity results
If using LabCorp the test # is 096560 Quest Diagnostic test # is 52449W

- 1 dose of the Mumps vaccine, or a Mumps IgG titer showing positive immunity results
If using LabCorp the test # is 096552 Quest Diagnostic test # is 64766R

- 1 dose of the Rubella vaccine, or a Rubella IgG titer showing positive immunity results
(It is okay to have 2 doses of MMR to satisfy the above)
If using LabCorp the test # is 006197 Quest Diagnostic test # is 83626F

- 2-step PPD * regardless of history of having received BCG
 - Please include date placed and date read with mm (millimeters) of induration
 - For a positive PPD, you must submit the date and size of induration, along with a current (within the past 12 months) chest x-ray report

- 3 doses of Hepatitis B vaccine are required. If all 3 doses have previously been received, you must have a QUANTITATIVE Hepatitis B Surface Antibody titer showing immunity.
If using LabCorp the test # is 006395 Quest Diagnostic test # is 51938W

- Hepatitis B Core Antibody and Hepatitis B Surface Antigen titers are **required**. This is to determine past or current infectivity.
If using LabCorp for HepBcAB Total test # is 006718 Quest Diagnostic test # is 51870E
If using LabCorp for HepBsAG test # is 006510 Quest Diagnostic test # is 265F

- 2 doses of the Varicella vaccine or a Varicella IgG titer showing positive immunity results
If using LabCorp the test # is 096206 Quest Diagnostic test # is 54031E

* From MMWR: Guidelines for Preventing The Transmission of *Mycobacterium Tuberculosis* in Health-Cater Settings, 2005. Two-step testing is recommended for healthcare workers (HCWs) whose initial Tuberculin Skin Test (TST)(PPD) results are negative. If the first-step TST result is negative, the second-step TST should be administered 1- 3 weeks after the first TST result was read. If either 1) the baseline first-step TST result is positive or 2) the first-step TST result is negative but the second-step TST result is positive, TB disease should be excluded, and if it is excluded, then the HCW should be evaluated for treatment of latent TB infection (LTBI). If the first and second-step TST results are both negative, the person is classified as not infected with *M. tuberculosis*. If the second test result of a two-step TST is not read within 48 – 72 hours, administer a TST as soon as possible (even if several months have elapsed) and ensure that the result is read within 48 -72 hours.

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HEPATITIS B RECORD

Name _____
Last Name First Name

Address _____
Street City State Zip

Date of Entry ____/____/____ Date of Birth ____/____/____ Social Security Number _____ - ____ - ____
Mo Yr Mo Dy Yr

School -- SCHOOL OF NURSING Program : BSN _____ MSN _____

Students who will participate in exposure-prone procedures* shall have their potential to transmit hepatitis B virus determined prior to matriculation, DESPITE previous immunization against hepatitis B.

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER (all items must be completed).

1. Hepatitis B surface antibody (anti-HBs) Neg/Pos ____/____ 1
 (titer must be quantitative *not* qualitative) Mo Yr
 (attach report)
2. Hepatitis B core antibody (anti-HBc) Neg/Pos ____/____ 2
 (attach report) Mo Yr
3. Hepatitis B surface antigen (HBsAg) Neg/Pos ____/____ 3
 (attach report) Mo Yr
 If positive, must include #3a
- 3a. Hepatitis Be antigen (HBeAg) (include if #3 is positive) Neg/Po..... ____/____
 (attach report) Mo Yr

Health Service Use Only	
Need	Ok

* According to the Centers for Disease Control (CDC), "characteristics of exposure-prone procedures include digital palpation of a needle tip in a body cavity or the simultaneous presence of the health care worker's fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site."

For the complete UMDNJ "Student Immunizations & Health Requirements" go to www.umdj.edu/opmweb/policies/contents.html and access "Student Services."

HEALTH CARE PROVIDER (must be completed):

Print Name _____ Address _____

Signature _____

Date _____ Phone (____) _____

MENINGOCOCCAL VACCINE

WHAT YOU NEED TO KNOW

1 What is meningococcal disease?

Meningococcal disease is a serious illness, caused by a bacteria. It is the leading cause of bacterial meningitis in children 2-18 years old in the United States. Meningitis is an infection of the brain and spinal cord coverings and is characterized by sudden onset of fever, intense headache, nausea and vomiting, stiff neck and frequently a specific type of rash. This disease is transmitted by respiratory droplet.

About 2,600 people get meningococcal disease each year in the U.S. 10-15% of these people die, in spite of treatment with antibiotics. Of those who live, some may become deaf, have problems with their nervous systems, become mentally retarded, or suffer seizures or strokes.

Anyone can get meningococcal disease. But it is most common in infants less than one year of age, and in people with certain medical conditions. College freshmen, particularly those who live in dormitories, have a slightly increased risk of getting meningococcal disease.

The risk of meningococcal disease among non-freshman college students is similar to that for the general population.

Meningococcal vaccine can prevent 2 of the 3 important types of meningococcal disease in older children and adults. Meningococcal vaccine is not effective in preventing all types of the disease. But it does help to protect many people who might become sick if they don't get the vaccine.

Drugs such as penicillin can be used to treat meningococcal infection. Still, about 1 out of every ten people who get the disease dies from it, and many others are affected for life. This is why it is important that people with the highest risk for meningococcal disease get the vaccine.

2 Who should get meningococcal vaccine and when?

Meningococcal vaccine is not routinely recommended for most people. People who *should* get the vaccine include:

- U.S. Military recruits
- People who might be affected during an outbreak of certain types of meningococcal disease.
- Anyone traveling to, or living in, a part of the world where meningococcal disease is common, such as West Africa.
- Anyone who has a damaged spleen, or whose spleen has been removed.
- Anyone who has terminal complement component deficiency (an immune system disorder).

The vaccine should also be *considered* for:

- Some laboratory workers who are routinely exposed to the meningococcal bacteria.

The vaccine may also be given to college students who choose to be vaccinated. College freshmen, especially those who live in dormitories, and their parents should discuss the risks and benefits of vaccination with their health care providers.

Meningococcal vaccine is usually not recommended for children under two years of age. But under special circumstances it may be given to infants as young as 3 months (the vaccine does not work as well in very young children). Ask your health care provider for details.

How many doses?

- For people 2 years of age and over: 1 dose (Sometimes an additional dose is recommended for people who continue to be at high risk. Ask your provider.)
- For children 3 months to 2 years of age who need the vaccine: 2 doses, 3 months apart

3 Some people should not get meningococcal vaccine or should wait

People should not get meningococcal vaccine if they have ever had a serious allergic reaction to a previous dose of the vaccine.

People who are mildly ill at the time the shot is scheduled can still get meningococcal vaccine. People with moderate or severe illnesses should usually wait until they recover. Your provider can advise you.

Meningococcal vaccine may be given to pregnant women.

4 What are the risks from meningococcal vaccine?

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of the meningococcal vaccine causing serious harm, or death, is extremely small.

Getting meningococcal vaccine is much safer than getting the disease.

Mild problems

Some people who get meningococcal vaccine have mild side effects, such as redness or pain where the shot was given. These symptoms usually last for 1-2 days.

A small percentage of people who receive the vaccine develop a fever.

5 What if there is a serious reaction?

What should I look for?

Look for any unusual condition, such as a severe allergic reaction, high fever, or unusual behavior. If a serious allergic reaction occurred, it would happen within a few minutes to a few hours after the shot. Signs of a serious allergic reaction can include difficulty breathing, weakness, hoarseness or wheezing, a fast heart beat, hives, dizziness, paleness, or swelling of the throat.

What should I do?

- Call a doctor, or get the person to a doctor right away.
- Tell your doctor what happened, the date and time it happened, and when the vaccination was given.
- Ask your health care provider to file a Vaccine Adverse Events Reporting System (VAERS) form, or call VAERS yourself at 1-800-822-7967.

6 How can I learn more?

- Ask your doctor or nurse or check with the Student Health Service on your campus.
- Call your local or state health department's immunization program.
- Contact the Centers for Disease Control and Prevention (CDC):
 - Call **1-800-232-2522** (English)
 - Call **1-800-232-0233** (Español)
 - Visit the National Immunization Program's website at **<http://www.cdc.gov/nip>**
 - Visit the National Center for Infectious Disease's meningococcal disease website at **http://www.cdc.gov/ncidod/dbmd/diseaseinfo/meningococcal_g.htm**

Adapted from CDC
Vaccine Information Statement
Meningococcal (3/31/2000)

**U.S. DEPARTMENT OF HEALTH &
HUMAN SERVICES**
Centers for Disease Control and Prevention
National Immunization Program

University of Medicine and Dentistry of New Jersey

Meningococcal Meningitis Response Form

Student Name: _____

Student Date of Birth: _____

UMDNJ School: GSBS NJDS NJMS RWJMS SHRP
 SN SOM SPH OTHER

Campus: Camden Newark Piscataway/New Brunswick
 Scotch Plains Stratford Other: _____

Meningitis Information

I have received information about the nature of meningococcal meningitis disease, disease prevention and treatment, and the availability of a meningococcal vaccine to prevent disease.

Yes() No()

Meningococcal Vaccine

Check one below:

() I have already received the meningococcal vaccine (/)
Date

() I have decided not to receive the meningococcal vaccine.

() I plan to receive the meningococcal vaccine in the future.

() I am undecided about receiving the meningococcal vaccine.

Student signature: _____ Date: _____

* This form shall become part of the student health record and is required by New Jersey law, P.L. 2000c.25.

Mail To: University Doctor's Pavilion
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Stratford, NJ 08084
Phone: 856-566-6825 Fax: 856-566-6188

IMMUNIZATION RECORD

Name Last Name First Name
Address Street City State Zip

Start Date Grad. Year Date of Birth Social Security #
Mo Yr Mo Yr Mo Dy Yr

School -- SCHOOL OF NURSING

Program Rotation

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER (all items must be completed).

A. ADULT Tdap (TETANUS, DIPHTHERIA & ACELLULAR PERTUSSIS)

1. Tdap if two or more years have passed since the last Td booster. M D Y A

B. M.M.R. (Measles, Mumps, Rubella)

1. Dose 1 given at 12 months after birth or later and Dose 2 after 1980 M D Y 2. M D Y B

OR INDIVIDUAL MMR AS SPECIFIED IN C, D and E:

C. MEASLES (Rubeola) (2 Doses of Live Vaccine Required)

1. Dose 1 of live vaccine at 12 months after birth or later and Dose 2 after 1980 M D Y 2. M D Y C
OR
2. Serologic immunity. Specify date (attach results) M D Y

D. RUBELLA (German Measles)

1. Live vaccine at 12 months after birth or later M D Y D
OR
2. Serologic immunity. Specify date (attach results) M D Y

E. MUMPS

1. Live vaccine at 12 months after birth or later M D Y E
OR
2. Serologic immunity. Specify date (attach results) M D Y

F. TUBERCULOSIS (PPD required regardless of prior BCG)

1. PPD (2 STEP) within the past 3 months. Result #1: mm induration (horizontal diameter). Date read M D Y F
If Result #1 < 10mm, PPD#2 must be done 1-3 weeks later. Result #2: mm induration (horizontal diameter). M D Y
2. All PPD's >10mm Date: mm induration: Was INH taken?: Yes ___ No ___ How long? ___
3. If 10mm, or greater, chest X-ray required within the past 12 months (attach report). X-ray result: Normal ___ Abnormal ___ Date: ___

G. HEPATITIS B

1. Completion of at least two of three required doses prior to the start of school: Dose #1 M D Y Dose #2 M D Y Dose #3 M D Y G
AND
2. Hepatitis B Surface Antibody Titer - Required 1 - 2 months after dose #3 (attach results) M D Y
(titer must be quantitative not qualitative)

H. VARICELLA (Chicken Pox)

1. Immunized (Varivax - 2 doses required) M D Y 2. M D Y H
OR
2. Serologic immunity. Specify date (attach results) M D Y

HEALTH CARE PROVIDER (must be completed)

Print Name Address

Signature

Date Phone ()

Table with 2 columns: Need, Ok. Rows correspond to immunization categories A through H.

Empty 3x3 grid table.

University Doctor's Pavilion
Employee and Student Health
42 East Laurel Road, Suite 2100
Stratford, NJ 08084
Phone: 856-566-6825 Fax: 856-566-6188

School: School of Nursing Program _____ Grad. Year _____
Name _____ Social Security Number _____
Home Address _____ Home Phone _____
Emergency Contact _____ Phone _____

HISTORY
(to be completed by patient)
PART 1

ALLERGIES: seasonal, medications, etc.: _____

CURRENT MEDICATIONS, SUPPLEMENTS: _____
(please list)

PAST SURGERIES: None YES(List by date with age):

ACCIDENTS: No injuries of consequence YES(List by date with age):

PAST ILLNESSES: No serious past illnesses YES(List by date with age):

HOSPITALIZATIONS: (List by date with reason):

FAMILY HISTORY: If any of the following run in your family, check appropriate block: Allergies Cancer
Tuberculosis Diabetes Heart Disease Strokes Hypertension Depression

SOCIAL HISTORY: Smoker: Now In past Never **Alcohol:** YES NO **Other drugs:** YES NO

REVIEW OF SYMPTOMS: Place a check mark in the appropriate blocks in the following lists of current or recent symptoms

<p>1. HEAD AND NECK</p> <table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">Yes</td><td style="text-align: center;">No</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td> </tr> <tr> <td>Headaches</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Ringing in ears</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Chronic nose obstruction</td><td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Failing vision</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Pain in ears</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Eye pain</td><td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Double vision</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Discharge from ear.</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Teeth problems</td><td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>See "floating lights"</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Repeated nosebleeds</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Severe hearing loss</td><td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Swellings in neck</td><td><input type="checkbox"/> <input type="checkbox"/></td><td></td><td></td><td></td><td></td> </tr> </table>	Yes	No	Yes	No	Yes	No	Headaches	<input type="checkbox"/> <input type="checkbox"/>	Ringing in ears	<input type="checkbox"/> <input type="checkbox"/>	Chronic nose obstruction	<input type="checkbox"/> <input type="checkbox"/>	Failing vision	<input type="checkbox"/> <input type="checkbox"/>	Pain in ears	<input type="checkbox"/> <input type="checkbox"/>	Eye pain	<input type="checkbox"/> <input type="checkbox"/>	Double vision	<input type="checkbox"/> <input type="checkbox"/>	Discharge from ear.	<input type="checkbox"/> <input type="checkbox"/>	Teeth problems	<input type="checkbox"/> <input type="checkbox"/>	See "floating lights"	<input type="checkbox"/> <input type="checkbox"/>	Repeated nosebleeds	<input type="checkbox"/> <input type="checkbox"/>	Severe hearing loss	<input type="checkbox"/> <input type="checkbox"/>	Swellings in neck	<input type="checkbox"/> <input type="checkbox"/>					<p>5. URINARY TRACT</p> <table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">Yes</td><td style="text-align: center;">No</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td> </tr> <tr> <td>Frequent urination</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Frequent night urination ..</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Passed stones</td><td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Hard to start urinary flow .</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Pain with urination</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Blood in urine</td><td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Scanty urination</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Leakage of urine</td><td><input type="checkbox"/> <input type="checkbox"/></td><td></td><td></td> </tr> </table>	Yes	No	Yes	No	Yes	No	Frequent urination	<input type="checkbox"/> <input type="checkbox"/>	Frequent night urination ..	<input type="checkbox"/> <input type="checkbox"/>	Passed stones	<input type="checkbox"/> <input type="checkbox"/>	Hard to start urinary flow .	<input type="checkbox"/> <input type="checkbox"/>	Pain with urination	<input type="checkbox"/> <input type="checkbox"/>	Blood in urine	<input type="checkbox"/> <input type="checkbox"/>	Scanty urination	<input type="checkbox"/> <input type="checkbox"/>	Leakage of urine	<input type="checkbox"/> <input type="checkbox"/>		
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<p>4. STOMACH AND INTESTINES</p> <table style="width: 100%; border: none;"> <tr> <td>Chronic abdominal pain <input type="checkbox"/> <input type="checkbox"/></td><td>Night sweats</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Clay colored stools</td><td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Persistent nausea</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Skin turns yellow</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Habitual constipation ...</td><td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Heartburn</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Chronic diarrhea</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Hemorrhoids</td><td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Appetite loss</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Black tarry stools</td><td><input type="checkbox"/> <input type="checkbox"/></td><td></td><td></td> </tr> </table>	Chronic abdominal pain <input type="checkbox"/> <input type="checkbox"/>	Night sweats	<input type="checkbox"/> <input type="checkbox"/>	Clay colored stools	<input type="checkbox"/> <input type="checkbox"/>	Persistent nausea	<input type="checkbox"/> <input type="checkbox"/>	Skin turns yellow	<input type="checkbox"/> <input type="checkbox"/>	Habitual constipation ...	<input type="checkbox"/> <input type="checkbox"/>	Heartburn	<input type="checkbox"/> <input type="checkbox"/>	Chronic diarrhea	<input type="checkbox"/> <input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/> <input type="checkbox"/>	Appetite loss	<input type="checkbox"/> <input type="checkbox"/>	Black tarry stools	<input type="checkbox"/> <input type="checkbox"/>			<p>8. NEURO-PSYCHOLOGICAL</p> <table style="width: 100%; border: none;"> <tr> <td>Depression</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Paralysis/weakness</td><td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Memory loss</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Alcohol problem</td><td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Personality changes</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Drug problem</td><td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Dizzy spells</td><td><input type="checkbox"/> <input type="checkbox"/></td><td>Speech disturbances</td><td><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>	Depression	<input type="checkbox"/> <input type="checkbox"/>	Paralysis/weakness	<input type="checkbox"/> <input type="checkbox"/>	Memory loss	<input type="checkbox"/> <input type="checkbox"/>	Alcohol problem	<input type="checkbox"/> <input type="checkbox"/>	Personality changes	<input type="checkbox"/> <input type="checkbox"/>	Drug problem	<input type="checkbox"/> <input type="checkbox"/>	Dizzy spells	<input type="checkbox"/> <input type="checkbox"/>	Speech disturbances	<input type="checkbox"/> <input type="checkbox"/>																					
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Provider: For Comments On Any Significant History Use the Space Below

CERTIFY THAT THE ABOVE IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE.

Signature

Date

**PART 2
UMDNJ STUDENT HEALTH SERVICES
PHYSICAL EXAMINATION**

Name _____ Age _____ Today's Date _____
Date of Birth _____

BP	Height	Weight
----	--------	--------

- NORMAL FINDINGS (No Mark = Not Examined)**
 ABNORMAL FINDINGS (describe at right)

General Appearance

- General Health Body Build
 Apparent Age Posture

Skin

- Texture No Skin Lesions
 Turgor Nails

Head and Neck

- Scalp Fundi Pharynx
 Ears Nose Sinuses
 Carotids Tongue Thyroid
 PERLA/EOMI Teeth No Adenopathy

Thorax/Breast

- CHEST No Deformity No Masses Excursion

HEART RRR No S3 or S4
 No Murmurs PMI not displaced
 No Thrills/Heaves No Ectopic beats

LUNGS No Crackles No Wheezes

BREAST No Masses No Tenderness SBE taught

Abdomen

- No Tenderness No Masses No HSM Sounds X 4
 No Hernia No Inguinal Nodes No Scars No Bruits

Female Genital (Recommended)

- Vulva Uterine Shape/Size _____ Adnexa
 Vagina Pap Done _____ Cervix

Male Genital

- Penis Testes No Hernia
 Uncir/Circ Scrotum No Masses

Rectal (Recommend over age 40)

- No Masses No Hemorrhoids
 No Stool Blood Prostate

Musculoskeletal

- EXTREMITIES No Clubbing No Swelling Pulses
 ROM No Deformities No Edema
BACK No Curvatures ROM No Tenderness

Neurological

- Cranial Nerves Sensory Exam Deep Tendon Reflexes
 No Weakness Gait Romberg Coordination

Mental Status

- Orientation Cognition Mood Language
 Memory Judgment Level of Consciousness Behavior

Vision **Color Blind** No Yes _____
Without Correction **With Correction**

Far R 20/____ L 20/____ Far R 20/____ L 20/____

Near R 20/____ L 20/____ Near R 20/____ L 20/____

Health Care Provider

Name _____

Address _____

Phone _____

Signature _____