INLAND HEALTHCARE RESOURCE NURSING ASSISTANT SCHOOL

4651 HOLT BLVD UNIT I

MONTCLAIR CA 91730

Medical-Physical Form

Personal Information

Name: _____ Date: _____

Address: _____

Phone: _____ Email: _____

DOB: _____ Sex: _____ Ethnicity: _____ Height: _____ Weight: _____

Primary Physician: _____ Phone: _____

Insurance Provider: _____ ID No. _____

Current Symptoms (Check All That Apply)

☐ Headaches	☐ Joint Pain/Swelling	☐ Dizziness	☐ Numbness
☐ Nausea	☐ Vision Impairment	☐ Hearing Impairment	☐ Weight Loss/Gain
☐ Fevers	☐ Coughing/Wheezing	☐ Fatigue	☐ Chest/Back Pain

Medical History

Exercise Frequency: _____ Exercise Type(s): _____

Smoking Frequency: _____ Drinking Frequency: _____

Illicit Drug Frequency: _____ Fast Food Frequency: _____

Allergies: _____

Current Medications: _____

Current Diagnoses: _____

Current Injuries: _____

Previous Injuries: _____

Previous Medications: _____

Dates Treated: _____

Previous Medical Conditions: _____

Previous Surgeries:

Vaccinations

Standard Childhood Vaccinations	☐Yes	☐No	Date: _____
Hepatitis A	☐Yes	☐No	Date: _____
Hepatitis B	☐Yes	☐No	Date: _____
Tuberculosis	☐Yes	☐No	Date: _____
Flu	☐Yes	☐No	Date: _____
MMR	☐Yes	☐No	Date: _____
Td/Tdap	☐Yes	☐No	Date: _____
Chicken Pox (vaccine or illness)	☐Yes	☐No	Date:

Occupational Hazards

Do you require a respirator, face mask, or nose/mouth guard? _____

Will you be lifting more than fifty pounds on a regular basis? _____

Will you be exposed to human fluids (blood, feces, etc.)? _____

Will you be exposed to poisonous or radioactive chemicals? _____

Will you be operating heavy machinery/driving a vehicle?

_____ _____

Signature Date