Physical Exam Form for
Radiologic Technology Students

www.columbiastate.edu
Phone: (931) 540-2849

Date of Exam: ______________________ **NOTE: Attach all Lab and Radiology reports to this form.**

Name of Student: ____ SS#: ___________________ Sex: ___________________

Age: _____________________________ Student Date of Birth: ____

Height: ____________ Weight: _____________ BP: ______________ Pulse: _____________ Temperature: ______________

Urinalysis: Protein ___________ Leukocytes _________ Glucose _____________ Blood ________ Bilirubin ______________

Hematocrit: _____________________________ CBC (optional) ____

Eyes: __________________________________Visual Acuity R ____________________ L __________________________

Color Blindness: Y_______N __________

Ears: __________________________________ Hearing: R ___________________ L__________________________

Nose: __________________________________ Oropharynx: ____

General condition of teeth (caries, dentures, braces, implants): ____

Skin: __________________________________ Breasts: ____

Musculo-skeletal system (joint instability, inflammatory conditions, surgical repairs): ______________ Spine: ________________

Cardiovascular: _________________________________ Respiratory: ____

Abdomen (pain, scars, masses, hernia): ____

Genito-urinary system: ___________________________ Hemorrhoids: _______________ Varicosities: __________________

Is this student in good physical condition? Yes__________ No _________

Reasons he/she is not: ____

____

____

Physician's recommendations for further testing or comments: ____

____

____

CoSCC AH-22-08-10
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Name of Student: ____________________

Address: ____________________ City: ____________ State: ____________ Zip Code: ____________

Student Home Phone Number: ____________________ Cell: ____________________

Date of T.B. skin test ***(required):*** Date Administered:____________ Date Read:____________ Result: ____________
TB skin test due 3 months prior to the start of classes

NOTE: If T.B. skin test is **positive**; you must submit a chest X-ray report. Date:____________ Results: ____________
(Attach Radiologist's report)

Date of Mumps Titer/IGG ***(required):*** ____________________**Attach lab report for result:** ____________

Date of Rubella Titer/IGG ***(required):*** ____________________ **Attach lab report for result:** ____________

Date of Rubeola Titer/IGG ***(required):*** ____________________ **Attach lab report for result:** ____________

NOTE: If no immunity, MMR immunization is required. Date of MMR #1 ____________ #2 ____________

MMR Booster: ____________________
You must repeat titer(s) two months (60 days) following immunization. **Attach lab report for result.**

Date of Varicella Zoster titer/IGG ***(required)*** ____________________ **Attach lab report for result:** ____________

If NOT immune: Date of Varicella Zoster immunization #1: ____________ #2: ____________
NOTE: You must repeat titer(s) two months (60 days) following immunizations. **Attach lab report for result.**

Have you had chicken pox? YES ____________ NO/NOT SURE ____________

Date of Influenza Vaccine (seasonal September-March): ____________

Date of Tetanus ***(required):*** ____________ ***You must have a booster if you vaccination is over 10 years old***

Date of Hepatitis B series (received): #1 ____________ #2 ____________ #3 ____________

Date of Hepatitis B titer **(Attach Hepatitis B titer lab report).** Results: ____________________
Hepatitis B vaccine series is optional, but the student will be required to sign a waiver if he/she decides not to receive it.

____________________, M.D./N.P.
Physician's or Nurse Practitioner's Signature

____
Physician's Address

____________________, M.D./N.P.
Print or type Physician's or Nurse Practitioner's Name

____
Date of Examination

Revised 07/10

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