



# Medical Form

*This form is to be submitted after you have been notified of acceptance into the JVC Northwest program.*

## Applicant Information

We prefer that this form is completed by a physician, nurse practitioner, or physician's assistant (other than a parent) who has been involved with the applicant's on-going, comprehensive care. When not possible, the form may be completed at a campus health center, or by a physician/nurse practitioner/physician's assistant with whom you do not have an ongoing history. **Type or print clearly.**

APPLICANT'S NAME

DATE OF EXAM

LENGTH OF TIME APPLICANT HAS BEEN YOUR PATIENT

## General Information

PAST HISTORY

PAST HOSPITALIZATIONS (INCLUDE SURGERIES)

DIAGNOSIS/TREATMENT OF ALCOHOL ABUSE

DIAGNOSIS/TREATMENT OF DRUG ABUSE

DIAGNOSIS/TREATMENT OF EATING DISORDERS OR OTHER MENTAL HEALTH ISSUES

SIGNIFICANT PAST ILLNESSES (INCLUDING MENTAL HEALTH DIAGNOSES)

FAMILY HISTORY (SIGNIFICANT MEDICAL/PSYCHIATRIC)

## Current Information

MEDICINES (INCLUDING RECURRENT NON-PRESCRIPTIVES)

SIGNIFICANT PRESENT MEDICAL CONDITIONS (INCLUDING PHYSICAL AND/OR MENTAL HEALTH)

ALLERGIES, DIETARY RESTRICTIONS

TOBACCO/ALCOHOL USES

*Please complete reverse side.*

## General Physical Information

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WT. HT. B.P. P.

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LAB (IF DONE RECENTLY): U/A CXR CBC

Note “✓” for normal, “X” for abnormal:

- |   |                                       |                                     |                                |
|---|---------------------------------------|-------------------------------------|--------------------------------|
| <input type="checkbox"/> General appearance | <input type="checkbox"/> Neurological | <input type="checkbox"/> Eyes       | <input type="checkbox"/> Ears  |
| <input type="checkbox"/> Nose               | <input type="checkbox"/> Mouth        | <input type="checkbox"/> Adenopathy | <input type="checkbox"/> Chest |
| <input type="checkbox"/> Heart              | <input type="checkbox"/> Abdomen      | <input type="checkbox"/> Skin       |                                |
| <input type="checkbox"/> Extremities        |                                       |                                     |                                |

*Expand on any abnormalities noted above in the space below.*

## Physician Information

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PHYSICIAN'S NAME SIGNATURE

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ADDRESS

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CITY STATE ZIP

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PHONE E-MAIL ADDRESS

*Return this form to the applicant.*