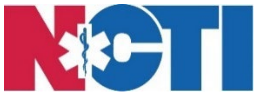

Paramedic Program

Health History Form

(To be completed by Licensed Physician or Mid-level Practitioner)

Patient's Name: ____ Age: _____________

Blood pressure: _____________ Pulse: _________ Height: __________ Weight: _________

Vision:	☐ Corrected	☐ Uncorrected	Far:	O.D.	20/	Near:	O.D.	20/
				O.S.	20/		O.S.	20/
				O.U.	20/		O.U.	20/

Color (Ishihara): ____

Rubella titer: ____

(or documentation of immunization)

Lab: Rubella titer (IGG) ____

<u>Or</u>,

- if DOB > January 1, 1957, documentation of two immunizations
- if DOB < January 1, 1957, documentation of one immunization

Varicella titer (if hx negative) ____

Hepatitis B titer (if hx negative) ____

(or documentation of Hep B series)

PPD or CXR ____

Other ____

Paramedic Program

Physical Exam

General Appearance	Normal	Abnormal (Describe Below)	General Appearance	Normal	Abnormal (Describe Below)
Head / Neuro			Eyes		
Ophthalmoscopic exam			Ears		

Nose			Mouth & teeth		
Throat			Neck		
Skin			Chest & breast		
Lungs			Heart		
Pulses			Abdomen exam / Hernia		
Liver/spleen			Upper extremities		
Lower extremities			Spine		

Comments/Recommendations: ______________________________

Restrictions: ______________________________

____

Signature (MD/DO completing physical) & Credentials   Name (please print)   Date