

**TENNESSEE STATE UNIVERSITY
DEPARTMENT OF DENTAL HYGIENE
Medical Examination Form for Accepted Applicants**

It is **mandatory** that this form be completed and submitted to the Department of Dental Hygiene after an applicant has been accepted into the program. This form should have the examining physician's signature.

Applicant Name: _____

SS#: _____ Date of Birth: _____ Marital Status _____

Permanent Address: _____

Telephone: Hm: _____ Cell: _____ Bus: _____

Current Address: _____

Do you have Health Insurance? Yes _____ No _____ Policy# _____

Company Name: _____

Have you had any of the following? Check Yes or No and Write Age.

Condition	Yes	No	Age	Condition	Yes	No	Age
Chicken Pox				Scarlet Fever			
Measles				Fever			
Rheumatic Fever				Pneumonia			
Whooping Cough				Meningitis			
Malaria				Poliomyelitis			
Typhoid				Mumps			
German Measles				Encephalitis			

Have you had any of the following conditions? Check Yes or No.

Condition	Yes	No	Condition	Yes	No
Skin Diseases			Ear Infection		
Blurred Vision			Sinusitis		
Wear Contacts			Nose Bleeds		
Color Blind			Swollen Glands		
Loss of Hearing			Night Sweats		
Dizziness			Asthma		
Severe Sore Throat			Allergies		
Paralysis			Diabetes		
Breathing Difficulty			Ulcers		
Head Injury			Bruise Easily		

Kidney Stones			Hernia		
Heart Murmur			Migraines		
Difficulty Breathing			Irregular Heart Beat		
High Blood Pressure			Swelling of Hands/Feet		
Hay Fever			Frequent Cough		
Kidney or Bladder Infection			Painful Urination		
Convulsions or Seizures			Stiffness of Joints		
Loss of Part or Whole Limb			Operation on Bones/Joints		
Free Bleeding Tendencies			Anemia		
Periods of Despondency			Periods of Confusions		
AIDS/HIV			Immunosuppressive Disorder		

Hepatitis B vaccine is required for all dental hygiene students. Begin the shots only after you have been accepted into the program.

Signature of Applicant: _____ Date: _____

If applicant is under 18, parent/guardian must sign.

Parent/Guardian: _____ Date: _____

To Be Filled Out By Examining Physician

Applicant Name: _____ Age: _____ Height: _____ Weight: _____

Blood Pressure: _____ / _____ Pulse Rate: _____

Eyes: With Glasses: R _____ L _____ Without Glasses: R _____ L _____

Ears: Hearing 20 Feet: R _____ L _____

Other Findings: _____ R _____ L _____

Conditions	Normal	Abnormal
Nose and Throat		
Sinuses		
Mouth and Teeth		
Ears		
Lungs (x-ray required if test positive)		
Chest		
Heart		
Abnormal Viscera		
Endocrine System		
Nervous System		
Lymphatic Glands		
Emotional Disturbances		
Orthopedic Defects		
Posture		
Nutrition		

Has the applicant ever suffered from physical, nervous, or mental disability? Yes _____ No _____

Laboratory Finding:

Urinalysis: Sp. Gr. _____ Albumen _____ Sugar _____ Hemoglobin _____
 Hct. _____ Sickle Cell Prep. _____ Blood Group: Rh Factor _____
 Rubella Titer _____ VDRL Report _____

Immunization Record: *It is recommended that Tetanus Inoculation be given.*

Do you consider the applicant in a state of health to assume a full program of study? Yes_ No__

Is the applicant at present on a medical regiment that may have to be continued while a student at Tennessee State University? Yes _____ No _____

Do you find need for any special therapeutic program? Yes _____ No _____

Remarks: _____

Signature: _____ Date: _____

Address: _____ Phone#: _____

City: _____ State: _____ Zip: _____