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Website: www.chicagoclerkships.com

Name_____Date of Birth _____

Address_____

Telephone_____Email_____

Name of Physician _____

Speciality _____

Office Address_____

Date of physical exam_____

General Health Circle YES or NO. If yes, please describe in the area below.

Any recent or continuing health concerns?	YES	or	NO
Any physical or learning disabilities:	YES	or	NO
Currently under care of a physician for an ongoing health issues?	YES	or	NO
Any surgeries?	YES	or	NO
Any food or drug allergies?	YES	or	NO
Any prescribed medications	YES	or	NO

Medical History Circle YES or NO. If yes, please describe in the area below.

Headaches requiring treatment	YES	or	NO
Epiliepsy/seizures	YES	or	NO
Asthma/lung disease	YES	or	NO
Heart disease	YES	or	NO
Anemia or bleeding disorder	YES	or	NO
Back/joint problems	YES	or	NO
Hypertension	YES	or	NO
Ulcer/colitis	YES	or	NO
Hepatitis/gallbladder disease	YES	or	NO
Bladder/kidney problems	YES	or	NO
Diabetes	YES	or	NO
Cancer/tumors	YES	or	NO
Thyroid problems	YES	or	NO
Recurrent infectious disease	YES	or	NO
Other	YES	or	NO

If you responded YES to any conditions above, please describe the condition, treatment, date, etc in detail below:

_____

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Certification

I certify that all responses made on this form are complete, true and accurate. I understand that If I misrepresented or failed to provide the information requested on this form, then the participant may be terminated from participation in or dismissed from his/her clinical rotations.

Signature of physician_____Date_____

LICENSED SPECIALIST
STAMP OR BUSINESS CARD