THE AMERICAN INSTITUTE OF MANAGEMENT SCIENCE INC

**Medical History Form**

150 South Pine Island Road, Suite 300

Plantation, Florida, 33324

CALL THE US TOLL FREE:

1-800-981-2810 / 786-923-1480

876-906-8085

*This form is to be filled out completely by the applicant and a Physician and returned to the Admissions office. This information is confidential and will be kept on file. The information herein will be used only in case of an emergency or medical situation.*

**STUDENT:**

Date:

Student ID:

Student Full Name:

Campus:

Semester:

Home Address:

Email Address:

Phone: ( )

Birth date:

**IN CASE OF EMERGENCY NOTIFY:**

Name: Relationship:

Phone:

Email:

Address:

**PSYSICIAN:**

Physician Name:

Physician’s ph. #:

Phone:

Email:

Address:

PHYSICIAN SIGNATURE:\_

DATE:

**STATEMENT BY STUDENT (OR PARENT/GUARDIAN IF STUDENT IS UNDER THE AGE OF 18)**

I understand that in case of any emergency requiring medical treatment, every effort will be made to reach one of the next of kin listed above. If he/she cannot be contacted, I authorize the school to give consent to treatment as deemed necessary by emergency responders. I also consent to accept all fees incurred in provide transportation and career where any is incurred.

Name of Guardian/s:

Signature of Guardian/s:

Date: \_

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**Applicant Self-Disclosure of Medical History and Information to review with your**

**Physician before sending to AIM**

**To the applicant: please circle Yes or No for each item. Each question must be answered.**

**GENERAL MEDICAL HISTORY**

Do you currently have or have you had a history of:

Respiratory problems? (e.g., asthma) 1. Yes No

Gastrointestinal conditions? (e.g., heartburn) 2. Yes No 3. Diabetes?

3. Yes No

Specific comments:

Hypertension? 4. Yes No

Bleeding or blood disorders? 5. Yes No

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Hepatitis or other liver disease? 6. Yes No

Specific comments:

Neurological problems? (e.g., seizure disorder) 7. Yes No

Dizziness or fainting episodes? 8. Yes No 9. Cardiac problems? 9. Yes No

Specific comments:

Disorders of the urinary or reproductive tract? 10. Yes No

Any other medical conditions or considerations that may affect your participation (including loss of hearing or vision)? 11. Yes No

Specific comments:

Do you see a Medical or Physical specialist of any kind? 12. Yes No

Physician Name\_

Address Are you pregnant? 13. Yes No

Specific comments:

**PERSONAL HISTORY (COUNSELLING/PSYCHIATRIC)**

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Have you had treatment or counseling with a mental health professional? 14. Yes No

Are you currently in treatment or counseling? 15. Yes No

Name and address of therapist

Hospitalization within the past year? 16. Yes No

Reasons for treatment or counseling?

 suicide gesture

 academic/career

 substance abuse/chemical dependency \_family issues/divorce

 eating disorder (anorexia/bulimia) \_learning disability

 other (please give specifics below) Specific comments:

**ALLERGIES**

Any environmental allergies?

17. Yes No

Is iodine contraindicated for you? 18. Yes No

Are you allergic to any foods? Do you have any dietary restrictions? 19. Yes No

Allergies to insect bites or bee stings? 20. Yes No

Specific comments:

Date of Last Tetanus Immunization?

**MEDICATIONS**

Are you allergic to any medications?

21. Yes No

Are you currently taking any medications? Please specify dose. 22. Yes No

Medication Dosage (amt./freq.) Side Effects/Restrictions

History of heat stroke or other heat related illness? 23. Yes No

Specific comments:

**FITNESS**

Do you exercise regularly? 24. Yes No

Intensity Level

Activity Frequency Duration/Distance Easy Moderate Competitive

Do you smoke? If so, how much?

25. Yes No

Are you in an appropriate weight range for your height? 26. Yes No

Swimming Ability (check one): \_non-swimmer \_recreational \_competitive

**Physician Physical Examination**

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To be completed by the Physician only: **Sign and use Medical Practice Stamp to authenticate**

Applicant/Patient’s Name:

Height: Blood Pressure:

Cardio-respiratory exam

Weight: Pulse:

Have you reviewed the applicant’s Medical History Form (4 pages)? Yes

No

**Please comment on specific areas from the Medical History Form that need elaboration.**

**Based on the information provided in the Medical History Form, their medical history self-disclosure and the physical examination, do you feel that this individual can participate in these Programs?**

 YES, I think this person can participate

 MAYBE, if the following restrictions or concerns can be accommodated in the program

 NO, this person should not participate at this time for the reasons below

**Comments (reasons, restrictions, or concerns):**

Examiner’s Name:

Phone:

Email:

Address:

PHYSICIAN SIGNATURE:

DATE:

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**Please return all original pages (including pages 1-5 of the Medical Form) to: The EdocuCenter**

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**Admissions Office:** 150 South Pine Island Road, Suite 300 Plantation, Florida, 33324

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