

| Name: | | | | | DOB: | |
|---|---|-------|---------|------------------------------------|------|--|
| Date of Examination: | | | | (within one year of matriculation) | | |
| B/P | _Temp | Pulse | | _WGT | HGT | |
| Allergies: | | Me | dicatio | n: | | |
| Reason for symptom Assessment: | | | | | | |
| To Be Completed by a Health Care Provider | | | | | | |
| | | | | | | |
| Has the student/p problems with a p | patient experienced ar persistent cough? | ny | | | | |
| Has the student/p in their sputum? | patient noticed any blo | ood | | | | |
| Has the student / p night sweats? | oatient experience any | У | | | | |
| Has the student/ precently? | oatient had a fever | | | | | |
| • | oatient experienced lo r weight loss lately? | OSS | | | | |
| Does anyone the sassociates with ha | • | | | | | |

Has the student/patient seen a healthcare