

2026-2027 HEALTH ASSESSMENT FORM

Basic Sciences and Clinical Sciences Medical Students

Physical Exam must be **completed within one year of start date**. All incoming medical students must return this completed, signed form **PRIOR TO MATRICULATION** through one of the following methods:

- Submit the form through the secured SIS by uploading it to the QUCOM Student Services Form; **OR**
- Email as PDF to clinicalsciences@qucom.edu.bb.

Student's Name: _____ QUCOM ID#: _____

Street Address: _____

City: _____ State: _____ ZIP: _____ Country: _____

Gender: ☐ Male ☐ Female ☐ Transgender: MTF FTM (Circle one) Other: _____

Date of Birth (mm/dd/yyyy): ____ / ____ / ____

Do you now have or have you ever had:

	No	Yes		No	Yes		No	Yes
Allergies/Asthma	☐	☐	Epilepsy/Seizures	☐	☐	Positive PPD Test or IGRA	☐	☐
Cancer	☐	☐	Gastrointestinal Disorder	☐	☐	Psychiatric/Behavior Disorder	☐	☐
Cardiovascular Disease	☐	☐	Hepatitis/Jaundice	☐	☐	Pulmonary/Lung Disease	☐	☐
Diabetes	☐	☐	High Blood Pressure	☐	☐	Skin Problems/Disease	☐	☐
Endocrine Disorder	☐	☐	Kidney/Urinary Disorder	☐	☐	Tobacco/Vaping use (current or past)	☐	☐
Alcohol/Drug abuse (current or past)	☐	☐	Musculoskeletal Disorder	☐	☐	Eating Disorder	☐	☐

Other illnesses/Comments (please explain any YES answers from above): _____

Allergies ☐ No ☐ Yes. If yes, list all allergies: _____

Surgeries ☐ No ☐ Yes (list dates): _____

Previous hospitalizations ☐ No ☐ Yes (list dates): _____

Current medications ☐ No ☐ Yes (list medications): _____

I attest that the information shown above is true and accurate to the best of my knowledge.

Student's Signature: _____ Date: _____

2026-2027 PHYSICAL EXAMINATION

*This page must be completed, signed, and stamped by a **non-relative** provider, nurse practitioner, or physician assistant.*

Patient's Name: _____ QUCOM ID#: _____ Date of Exam: _____

Height: _____ Weight: _____ BMI: _____ Temp: _____ BP: ____ / ____ Pulse: _____ RR: _____
 Vision: OD _____ OS _____ OU _____ Without correction: _____
 OD _____ OS _____ OU _____ With correction: _____

History/Current Alcohol/Drug abuse: ☐ No ☐ Yes _____

	Normal	Abnormal	Comments
HEENT	☐	☐	_____
Neck	☐	☐	_____
Lungs	☐	☐	_____
Heart	☐	☐	_____
Abdomen	☐	☐	_____
GU	☐	☐	_____
Extremities	☐	☐	_____
Neurologic	☐	☐	_____
Adenopathy	☐	☐	_____
Skin	☐	☐	_____
Psychiatric	☐	☐	_____

How long and on what basis have you known this patient?

Months: _____ Years: _____ ☐ This visit only ☐ Professional basis

To your knowledge, does this patient have any significant medical problems? ☐ No ☐ Yes

Explain: _____

To your knowledge, does this patient have any emotional, psychological or psychiatric problems? ☐ No ☐ Yes

Explain: _____

Clearance to be able to withstand the rigors of his/her program of study:

☐ Physically and psychologically cleared for this program

☐ Not cleared:

☐ Pending further evaluation. Explain: _____

☐ Not Cleared: No pending evaluation

Healthcare Provider Signature: _____ Date: _____

Healthcare Provider Printed Name: _____ ☐ MD ☐ DO ☐ NP ☐ PA

Address: _____ Phone: (____) _____

Healthcare Provider (MD, DO, NP, PA) Facility Stamp **(REQUIRED)**: