ACMC MEDICAL EDUCATION OFFICE
HEALTH RECORD

Please print

MEDICAL STUDENT, YEAR ______

Name____

Last **First** **MI**

Social Security Number ________________ Birth Date ______ Male or Female (circle one)

HEALTH INFORMATION – TO BE COMPLETED BY HEALTH CARE PROVIDER

RESULTS FROM AN INITIAL 2-STEP PPD OR QUANTIFERON OR CHEST X-RAY FOLLOWED BY AN ANNUAL PPD, ANNUAL QUANTIFERON OR CHEST X-RAY EVERY TWO YEARS

PPD Skin Test#1 __________________ READ ______________________ RESULT ____________

PPD Skin Test #2 __________________ READ ______________________ RESULT ____________

Or

Chest X-Ray ______________________ RESULT _____________________________________

Previously treated for a positive PPD or Active Disease? Yes _____ No _______

When? ______________________________ How Long?____________________

Tetanus Date ____________________

Rubella: 1)__________2)_________or Titer Date __________Result__________

Measles: 1)__________2)_________or Titer Date __________Result__________

Varicella: 1)__________2)_________or Titer Date __________Result__________

Hepatitis B: 1)__________2)_________or Titer Date __________Result__________

Anti-HBS Date ___________________Result_______________(Required)

TB Respirator: Fit Test Date ____________________Size__________Model__________

HEALTH CARE PROVIDER INFORMATION (must be completed by health care provider)

Signature __________________________________ **Date** _________________________

Printed Name ________________________________