Myotherapy Institute
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Health Statement

This form is to be completed and submitted by the physician's office.

Physical

Patient Name____Date____________

M/F_______ Ht._________ WT._________ B.P._________ Pulse_________

Hearing Deficit______________________________ Visual Deficit______________________

Indicate and explain any abnormalities:

____

____

To the best of your knowledge is the patient free of communicable disease today? YES NO

Laboratory

CBC_____________________

Indicate abnormalities____

PPD Date __________ Negative__________ Positive__________ Follow Up_____________

Tuberculosis Negative Positive ____

Immunizations

Month/Day Year

Tetanus
_____/_____/_____

Rubeola
_____/_____/_____

Polio last date
_____/_____/_____
_____/_____/_____

Mumps
_____/_____/_____

Hepatitis B (optional)
_____/_____/_____

Rubella
_____/_____/_____
_____/_____/_____

Varicella
_____/_____/_____
_____/_____/_____

Current Medications

____

____

General

Is this patient currently under medical supervision?

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Print Physician Name____________________________________Telephone_______________

Address____

Physician's Signature_________________________________ Examination Date____________