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 _____
Indicateabnormalities_____
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

If this patient is currently under medical supervision.
_____
_____
_____

Print Physician Name _____ Telephone _____

Address _____

Physician's Signature _____ Examination Date _____