SHEEPGATE

Physical Exam Form

Name: _____ Exam Date: _____

Signature for Release: _____ Date: _____

SSN: ____/____/____ Date of Birth: ____/____/____

Gender: ☐ Male ☐ Female

Below this line for medical staff only

Height: _____

Weight: _____

Hair Color: _____

Eye Color: _____

Ambulatory: ☐

Non-Ambulatory: ☐

Required Labs	Result
TB:	
Hepatitis ABC:	
HIV:	
CBC:	
Covid:	
Tetanus:	
Pregnancy (all females):	
PAP (all females):	

Please check any conditions requiring further medical treatment:

☐ Eyes	☐ Dental	☐ Extremities	☐ Lymph	☐ Abdomen
☐ Ears	☐ Neck	☐ Bones/Joints	☐ Lungs	☐ Back
☐ Nose	☐ Thyroid	☐ Neurological	☐ Heart	☐ Genital
☐ Throat	☐ Skin		☐ Vascular	☐ Rectal

Comments: _____

_____

List all medications the applicant is currently taking:

Medication	*Dosage*	*Purpose*

Does this applicant have a medical condition that might endanger the health of staff or students in our program?

☐ Yes ☐ No Explain: _____

Is there any reason why this applicant should not assist in the preparation of food or medical services?

☐ Yes ☐ No Explain: _____

Health History

Allergies: _____

Diet: _____

Glasses: _____

Contacts: _____

Dentures: _____

Hearing Aid(s): _____

Ever withdrawn from alcohol? _____

Ever withdrawn from chemicals? _____

How many times in detox? _____

How many times in outpatient treatment? _____

How many times in inpatient treatment? _____

Date of last drug/alcohol use: _____

	Yes	No
Headaches		
Dizziness		
Difficulty seeing		
Difficulty hearing		
Frequent earaches		
Hallucinations		
Shortness of breath		
Chronic cough		
Frequent colds		
Sinusitis		
Dental problems		
Bleeding gums		
Seizures		
Loss of appetite		
Compulsive eating		
Induced vomiting		
Vomiting		
Eating disorders		
Anemia		
Arthritis		
Athlete's foot		
Blood disorder		
Bruise easily		
Cancer		
Diabetes		
Dry skin		

	Yes	No
History of infection		
Starvation		
Weight loss		
Nausea		
Chest Pain		
Palpitations		
Heartburn		
History of high blood pressure		
Numbness of hands		
Liver disease		
Abdominal cramps		
Diarrhea		
Constipation		
Hemorrhoids		
Frequent urination		
Burning with urination		
Blood in urine		
Black, tarry stools		
Jaundice		
Lice/Crabs		
Rashes		
Skin problems		
Slow healing		
STD		
Tuberculosis		
Unusual discharge		

Please Fax or Mail both pages of this form and lab results to:

Sheepgate Admissions
900 N League Rd. | PO Box 185
Colfax, Iowa 50054
(515) 674-3713 or (800) 718-8804 phone
(515) 864-0094 fax

Physician's Name: _____

Physician's Signature: _____

Name of Practice: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: ( )_____- _____

Fax Number: ( )_____- _____