



PERSONAL MEDICAL HISTORY

Student Completes

Student Name _____

MEDICAL HISTORY

Do you have, or have you ever had, any of the following medical conditions?

Yes **No**

- Absence/damage to any paired organ (kidney, eye, etc.)
- Acne (under treatment)
- Alcohol or drug use, problem or treatment
- Anxiety or nervousness
- Anemia
- Arthritis
- Asthma
- Bipolar disorder/manic depression
- Blood disorders or Bleeding trait
- Breast disease
- Cancer or malignancy
- Cerebral palsy
- Chicken pox
- Chronic bronchitis/emphysema
- Chronic inflammatory bowel disease (Crohn's, ulcerative colitis)
- Chronic kidney condition
- Depression
- Diabetes Mellitus
- Digestive trouble
- Dizziness/fainting
- Ear infections/hearing problems
- Eating disorders: bulimia/anorexia nervosa
- Emotional/mental illness
- Fracture/sprains
- Hay Fever
- Hepatitis
- Heart Disease
- High cholesterol
- HIV/AIDS
- Insomnia/sleep problems
- Kidney disease (congenital or other)
- Menstrual problems
- Mental health issues
- Migraine/recurrent headaches
- Orthopedic problems/injuries
- Pelvic infection
- Peptic ulcer
- Phlebitis
- Pregnancy
- Rheumatic fever
- Seizure disorder (epilepsy)
- Sexually transmitted disease
- Skin disorder
- Systemic lupus
- Thyroid disorder
- Tobacco use
- Tuberculosis or past positive tuberculin skin test
- Treatment to prevent tuberculosis
- Treatment for active tuberculosis
- Urinary infection
- Other: Explain below

If yes to any of the above, explain: _____

Have you had any surgery? Explain: _____

Have you been hospitalized? Explain: _____

Other medical concerns (specify) _____

ALLERGIES AND OTHER SEVERE ADVERSE REACTIONS

No known allergies

- Aspirin
- Penicillin
- Latex
- X-ray contrast
- Other (specify) _____
- Insect/bee sting
- Sulfa
- Lidocaine/xylocaine
- Food

Please describe allergic reaction: _____

CURRENT MEDICATIONS (frequent or regular)

- No medication
- Acne medication
- ADHD/ADD medication
- Allergy medication
- Allergy shots
- Anti-depressants
- Anxiety medication
- Asthma medication
- Birth control pills
- Bowel medication
- Headache medication
- Heart rhythm medication
- Insulin
- Over the counter (OTC's)
- Pain medication
- Seizure medication
- Thyroid medication
- Other: (specify) _____

Please provide name, dosage and medical indication for **ALL** medication you are currently taking: _____

FAMILY MEDICAL HISTORY

Check the appropriate box(s), if any, of the following diseases that apply to your family.

- | Grand-
Parent(s) | Parent(s) | Sibling(s) | |
|--------------------------|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism or drug addiction |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Emotional/mental illness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sudden death before 35 years |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other (please specify) |

None of the above



PHYSICAL EXAMINATION

Health Care Provider Completes

Student Name _____ Birth Date _____ - _____ - _____

Sex	Age	Height	Weight
Blood Pressure:	Pulse:	Allergies:	
Vision: Right 20/ Left 20/	Corrected: Right 20/ Left 20/	Color Vision:	Hearing: Right Left

CLINICAL EVALUATION - Check each item in proper column. Enter NE if Not Evaluated

	<u>Normal</u>	<u>Abnormal</u>	<u>Notes/Details</u>
1. Skin (scars, tattoos)			
2. Ears			
3. Head/eyes			
4. Nose			
5. Mouth/teeth			
6. Throat/Neck			
7. Lymphatic			
8. Chest/breast			
9. Heart			
10. Lungs			
11. Abdomen (including hernia)			
12. Endocrine			
13. Allergic/Immunologic			
14. Genito/urinary			
15. Rectal/pelvic			
16. Extremities (strength, ROM, etc.)			
17. Spine/other musculo-skeletal			
18. Neurologic			
19. Psychiatric			

ADDITIONAL COMMENTS:

Intercollegiate Athletics

Nursing Student

Clearance _____ Yes _____ No _____ Yes _____ No _____

Comments: _____

Examining Health Care Provider Name (Please Print) _____

Signature Examining Health Care Provider _____ Date: _____

Address _____ Phone (____) _____ Fax (____) _____

IMMUNIZATION RECORD

Health Care Provider Completes

Student Name _____ Birth Date _____ - _____ - _____

IMMUNIZATION	Month / Day/Year	Initials of certifying health professional	Physician diagnosed disease history (date of onset)	Titers
Combined MMR REQUIREMENTS AS NOTED BELOW <p style="text-align: center;">OR</p>	#1 #2			Laboratory Report MUST be attached
MEASLES - TWO DOSES ARE REQUIRED If born after 1/1/57, 2 doses LIVE vaccine: #1 no more than 4 days prior to the first birthday, #2 at least 30 days after the first dose. Positive titer or physician documentation of having the disease are acceptable in lieu of the vaccine.	#1 #2			Laboratory Report MUST be attached
MUMPS - ONE DOSE REQUIRED If born after 1/1/57, 1 dose LIVE vaccine given AFTER the first birthday. Positive titer or physician documentation of having the disease are acceptable in lieu of the vaccine.				Laboratory Report MUST be attached
RUBELLA - ONE DOSE REQUIRED If born after 1/1/57, 1 dose LIVE vaccine given AFTER the first birthday. Positive titer is acceptable in lieu of the vaccine. Nursing Students— Require a positive numeric result			Not Acceptable	Laboratory Report MUST be attached
MENINGOCOCCAL MENINGITIS - ONE DOSE REQUIRED OR Completed Meningococcal Meningitis Response Form indicating declination of a Meningococcal Meningitis vaccine			A SUNYIT provided Meningococcal Meningitis Response Form MUST be completed by the student in lieu of the vaccine.	
The following are recommended but NOT required				
TETANUS/DIPHTHERIA —most recent dose within 10 years				
VARICELLA				
HEPATITIS B Nursing Students— Require documentation of the complete series OR completion of the waiver form	#1 #2 #3			

PPD (Mantoux): document only if completed within the past year: Date Placed _____ Date Read _____ Results _____ mm induration

(Note: Nursing Students require documentation of an annual Mantoux Test)

If student has a prior history of a positive PPD: Chest X-Ray date _____ Results _____

Signature of Health Care Professional _____ Date _____

Return to: SUNYIT Health & Wellness Center 100 Seymour Road Utica, NY 13502 Fax: 315.792.7371

