



# Health History & Physical Examination Form

Health & Wellness Center  
P.O. Box 3050 Utica, NY 13504  
Phone: 315.792.7172  
Fax : 315.792.7371

**DUE DATE: August 15th for the Fall Semester January 15th for the Spring Semester**

1. According to NYS Health Law, all students registered for 6 or more credits must provide proof of immunity to measles, mumps & rubella and either receive or decline the meningitis vaccine. Failure to do so will result in withdrawal from class.
2. All full time students must provide documentation of a health history and physical exam within the last 2 years by a health care provider (physician, nurse practitioner or physician assistant). Failure to do so will result in an academic hold, resulting in an inability to obtain grades or register for additional courses.
3. **Information on this form is confidential.** It is for use at the Health & Wellness Center only and will not be released without the student's written consent, or a court order.

### Student Identification

Student ID #/Social Security# \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle

Local Address (if Available) \_\_\_\_\_  
 \_\_\_\_\_

Home address \_\_\_\_\_  
 \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_

Birth date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Sex :  Female  Male

Race :  White/Non Hispanic  Native American  
 Black  Asian  
 Hispanic  Indian  
 Other

### College Related Information

Entering term:  Fall  Spring Year \_\_\_\_\_

Year expected to graduate: \_\_\_\_\_

Freshman  Sophomore  
 Junior  Senior  Graduate

Dormitory resident :  Yes  No

International student :  Yes  No

### Current Health Care Provider (Physician)

Name \_\_\_\_\_

Address \_\_\_\_\_  
 \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

### Emergency Contact

Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
 \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_

Business phone (\_\_\_\_) \_\_\_\_\_

Relationship \_\_\_\_\_

### Health Insurance

Will the student have health insurance coverage upon entrance?  Yes  No

**Please note:** Health Insurance is mandatory at SUNYIT. Billing is automatic unless you waive (each semester) the designated SUNYIT health insurance. Once you receive your PIN number at registration, you may waive the health insurance electronically.

### **Consent for Medical Care:**

**All** fulltime students **OR** parent/guardian of students *under 18 years of age* at registration **MUST** sign. I hereby give permission to the SUNYIT medical/nursing staff to examine and treat (Student's name) \_\_\_\_\_ for all medical problems/injuries while he/she is at SUNYIT. In the event of time restraints, or that I cannot be reached, I hereby give permission for the Health & Wellness Center staff to secure consultative care that may include hospitalization, anesthesia, surgery and/ or other medical treatment.

**OR**

\_\_\_\_\_  
Student signature over 18 years of age

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/guardian signature of a student under 18 years of age

\_\_\_\_\_  
Date



# PERSONAL MEDICAL HISTORY

Student Completes

Student Name \_\_\_\_\_

## MEDICAL HISTORY

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

- |                          |                          |                                                                  |
|--------------------------|--------------------------|------------------------------------------------------------------|
| <u>Yes</u>               | <u>No</u>                |                                                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Absence/damage to any paired organ (kidney, eye, etc.)           |
| <input type="checkbox"/> | <input type="checkbox"/> | Acne (under treatment)                                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol or drug use, problem or treatment                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety or nervousness                                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia                                                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis                                                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma                                                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Bipolar disorder/manic depression                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding trait                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood disorders                                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast disease                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer or malignancy                                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Cerebral palsy                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Chicken pox                                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic bronchitis/emphysema                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic inflammatory bowel disease (Crohn's, ulcerative colitis) |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic kidney condition                                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression                                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes Mellitus                                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Digestive trouble                                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/fainting                                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear infections/hearing problems                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Eating disorders: bulimia/anorexia nervosa                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Emotional/mental illness                                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Fracture/sprains                                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever                                                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis                                                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease                                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | High cholesterol                                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS                                                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Insomnia/sleep problems                                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease (congenital or other)                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Menstrual problems                                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Migraine/recurrent headaches                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Orthopedic problems/injuries                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Pelvic infection                                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Peptic ulcer                                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Phlebitis                                                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy                                                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever                                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure disorder (epilepsy)                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted disease                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin disorder                                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Systemic lupus                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disorder                                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco use                                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis or past positive tuberculin skin test               |
| <input type="checkbox"/> | <input type="checkbox"/> | Treatment to prevent tuberculosis                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Treatment for active tuberculosis                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary infection                                                |
| <input type="checkbox"/> |                          | 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

- |                                                |                                              |
|------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Aspirin               | <input type="checkbox"/> Insect/bee sting    |
| <input type="checkbox"/> Penicillin            | <input type="checkbox"/> Sulfa               |
| <input type="checkbox"/> Latex                 | <input type="checkbox"/> Lidocaine/xylocaine |
| <input type="checkbox"/> X-ray contrast        | <input type="checkbox"/> Food                |
| <input type="checkbox"/> Other (specify) _____ |                                              |

Please describe allergic reaction: \_\_\_\_\_

## CURRENT MEDICATIONS (frequent or regular)

- |                                              |                                                   |
|----------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> No medication       | <input type="checkbox"/> Bowel medication         |
| <input type="checkbox"/> Acne medication     | <input type="checkbox"/> Headache medication      |
| <input type="checkbox"/> ADHD/ADD medication | <input type="checkbox"/> Heart rhythm medication  |
| <input type="checkbox"/> Allergy medication  | <input type="checkbox"/> Insulin                  |
| <input type="checkbox"/> Allergy shots       | <input type="checkbox"/> Over the counter (OTC's) |
| <input type="checkbox"/> Anti-depressants    | <input type="checkbox"/> Pain medication          |
| <input type="checkbox"/> Anxiety medication  | <input type="checkbox"/> Seizure medication       |
| <input type="checkbox"/> Asthma medication   | <input type="checkbox"/> Thyroid medication       |
| <input type="checkbox"/> Birth control pills | <input type="checkbox"/> 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.

- | <u>Parent(s)</u>         | <u>Grand-Parent(s)</u>   | <u>Sibling(s)</u>        |                              |
|--------------------------|--------------------------|--------------------------|------------------------------|
| <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)			
17. Spine/other musculo/skeletal			
18. Neurologic			
19. Psychiatric			

### ADDITIONAL COMMENTS:

Clearance for athletics (intercollegiate and intramural/club): Yes \_\_\_\_\_ No \_\_\_\_\_  
 Clearance pending further evaluation (please comment below): Yes \_\_\_\_\_ No \_\_\_\_\_  
 Clearance with limitations (please comment below): Yes \_\_\_\_\_ No \_\_\_\_\_  
 Not able to participate in athletics: \_\_\_\_\_  
 Comments \_\_\_\_\_

Examining Health Care Provider (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—date/results Lab report results MUST be attached
<b>MEASLES - TWO DOSES ARE REQUIRED</b> If born after 1/1/57, 2 doses LIVE vaccine: #1 AFTER 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			
<b>MUMPS - ONE DOSE REQUIRED</b> 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.				
<b>RUBELLA - ONE DOSE REQUIRED</b> If born after 1/1/57, 1 dose LIVE vaccine given AFTER the first birthday. Positive titer is acceptable in lieu of the vaccine.			Not acceptable	
<u>OR</u> Combined as <b>MMR</b> REQUIREMENTS AS NOTED ABOVE	#1  #2			
<b>MENINGOCOCCAL MENINGITIS - ONE DOSE REQUIRED</b> <u>OR</u> 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 immunizations are recommended but NOT required.				
TETANUS/DIPHTHERIA – most recent dose within 10 years				
VARICELLA				
HEPATITIS B	#1  #2  #3			

PPD (Mantoux) - if completed within the past year: Date Placed \_\_\_\_\_ Date Read \_\_\_\_\_ Results \_\_\_\_\_ mm induration

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

Was treatment initiated? If yes, please explain \_\_\_\_\_

Signature - Health Care Provider \_\_\_\_\_ Date \_\_\_\_\_

Return to: SUNYIT Health & Wellness Center P.O. Box 3050 Utica, NY 13504 Fax: 315.792.7371

