

Student's Name: _____ Date of birth: _____

Home address: _____

To the student: please complete the other side of this form before taking it to your health care provider.

HEALTH CARE PROVIDER'S REPORT OF PHYSICAL EXAMINATION

To the examining health care provider: Please review the student's history (on the back of this form) and complete the provider's form below, as well as the student's immunization record. Please comment on all positive answers. This student has been accepted — the information supplied will not affect his/her status; it will be used only as a background for providing health care, if this is necessary. This information is strictly for use of the University Health Service and will not be released without student consent.

Laboratory data (required for all students)

Height _____ Weight _____ B/P _____ Pulse _____

Visual acuity: uncorrected _____ corrected _____ Circle one: glasses contact lens both

HCP Evaluation

Date of examination _____ Name of provider (please print) _____

Physical examination is within normal limits: Yes No If abnormal, please explain and attach a copy of your report:

Have you treated this student for any significant disease or medical problem other than minor short term illness? Yes No

If so, please explain _____

Is this student currently under your care and on medication? Yes No If so, please explain _____

Does this student have drug allergies? Yes No If yes, please list _____

How can we be of assistance to you in the care of your patient? Attach a copy of evaluation and recommendations, or explain _____

Do you consider this student physically and emotionally capable of handling college academics/life? Yes No Doubtful

If "no" or "doubtful," please give reasons _____

In your opinion is he/she physically qualified for: (please circle) unrestricted restricted athletics, exercise or walking?

If restricted, list basis for restriction _____

Is restriction permanent? Yes No or temporary? Yes No If temporary, for how long? _____

Does the student have any food allergies? Yes No If yes, please list _____

Is the student on a special diet or have other dietary restrictions? Yes No If yes, please explain _____

Signature of examining health care provider _____

Phone (_____) _____ Fax (_____) _____

Address _____

City _____ State/Zip _____

■ **This side to be completed by student before taking to health care provider.**

Student's Name: _____ Date of birth: _____

FAMILY MEDICAL HISTORY

	Age	Occupation	State of health	If deceased, age at death	Cause of death
Father					
Mother					
Brothers					
Sisters					

List family history and relationship to you of any disease such as diabetes, hypertension, heart disease, cancer, etc.: _____

HEALTH HISTORY

If you have ever had any of the following conditions or symptoms, please place a check mark in the appropriate box.

<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	Chicken pox (Year?)	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Irritable bowel syndrome	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Kidney stone	<input type="checkbox"/>	Sexually transmitted disease
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Drug/alcohol problem	<input type="checkbox"/>	Malaria	<input type="checkbox"/>	Skin problems
<input type="checkbox"/>	Back problems	<input type="checkbox"/>	Eating disorder	<input type="checkbox"/>	Migraine headaches	<input type="checkbox"/>	Thyroid problem
<input type="checkbox"/>	Blood disorder/anemia	<input type="checkbox"/>	Eye injury or disease	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Bone/joint problems	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	Neurological disorder	<input type="checkbox"/>	Ulcer — stomach or duodenal
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Urinary infection/problems
<input type="checkbox"/>	Cardiac problem	<input type="checkbox"/>	Hepatitis (jaundice)	<input type="checkbox"/>	Recurrent bronchitis	<input type="checkbox"/>	Other
<input type="checkbox"/>	Chest pain/shortness of breath	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Recurrent sinusitis	<input type="checkbox"/>	

Females only

<input type="checkbox"/>	Abnormal pap smear	<input type="checkbox"/>	Breast mass	<input type="checkbox"/>	Female surgery
<input type="checkbox"/>	Irregular periods	<input type="checkbox"/>	Severe cramps	Are you on medication for cramps or regulation of periods? ___ Yes ___ No If so, name: _____	

Explain conditions checked: _____

Are you currently taking any medications? ___ Yes ___ No If so, list names: _____

Do you have any drug allergies? ___ Yes ___ No If so, name drug: _____

Do you have any other allergies? ___ Yes ___ No If so, explain: _____

Have you ever been admitted to a hospital? ___ Yes ___ No If so, please give date and reason for admission: _____

Do you have any physical challenges or conditions that may impact your activity? ___ Yes ___ No If so, explain: _____

Have you ever had treatment for nervous or emotional problems? ___ Yes ___ No If so, explain: _____

By whom were you treated? _____ Address: _____

If medication used for treatment, name: _____

Have you ever been treated for an eating disorder? ___ Yes ___ No If so, explain: _____

MENTAL HEALTH HISTORY

Do you have, or have you experienced, any of the following:

Yes	No	Condition	Yes	No	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Family alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Recent death of a loved one
<input type="checkbox"/>	<input type="checkbox"/>	Drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	Feelings of sadness or loneliness
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	Feelings of depression
<input type="checkbox"/>	<input type="checkbox"/>	Rape or sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty sleeping
<input type="checkbox"/>	<input type="checkbox"/>	Dating or domestic violence	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty controlling temper

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TUBERCULOSIS RISK

To be completed by the student: Please answer all of the TB risk questions. When answering please refer to the list of countries at right that have high rates of tuberculosis.

1. Have you had a positive TB test in the past? Yes No
If yes, please skip to question 6 — you should not have your TB test repeated.
2. To the best of your knowledge have you had close contact with anyone who was sick with tuberculosis? Yes No
3. Were you born in one of the countries on the list at right? Yes No
4. Have you traveled or lived for more than one month in any of the countries on the list? Yes No
5. If you have answered "yes" to questions 2, 3, or 4 you need to provide documentation of a recent PPD test (within the past year). PPD test date: _____
Results: _____
6. If a current or past PPD test is positive you will need to obtain a chest x-ray and complete the following information:
Chest x-ray date: _____ Results: Positive Negative
Did you complete 6–9 months of medicine for TB (isoniazid)? Yes No
If no, please report to the University Health Service upon arrival to campus to discuss preventive (prophylactic) therapy for tuberculosis.

- | | |
|----------------------|-----------------------|
| Afghanistan | Lithuania |
| Angola | Macao SAR |
| Armenia | Macedonia |
| Azerbaijan | Madagascar |
| Bahamas | Malawi |
| Bahrain | Malaysia |
| Bangladesh | Maldives |
| Belarus | Mali |
| Benin | Marshall Islands |
| Bhutan | Mauritania |
| Bolivia | Mauritius |
| Bosnia | Micronesia |
| Botswana | Moldova Rep. |
| Brazil | Mongolia |
| Brunei Dar. | Morocco |
| Burkina Faso | Mozambique |
| Burundi | Myanmar |
| Cambodia | Namibia |
| Cameroon | Nepal |
| Cape Verde | New Caledonia |
| Central African Rep. | Nicaragua |
| Chad | Niger |
| China | Nigeria |
| Colombia | Niue |
| Comoros | Northern Mariana Isl. |
| Congo | Pakistan |
| Congo, DR | Palau |
| Cote d'Ivoire | Panama |
| Croatia | Papua New Guinea |
| Djibouti | Paraguay |
| Dominican Rep. | Peru |
| Ecuador | Philippines |
| El Salvador | Principe |
| Equatorial Guinea | Romania |
| Eritrea | Russian Federation |
| Estonia | Rwanda |
| Ethiopia | Sao Tome |
| Gabon | Senegal |
| Georgia | Sierra Leone |
| Ghana | Solomon Islands |
| Guam | Somalia |
| Guatemala | South Africa |
| Guinea | Sri Lanka |
| Guinea-Bissau | Sudan |
| Guyana | Suriname |
| Haiti | Swaziland |
| Herzegovina | Syrian Arab Rep. |
| Honduras | Tajikistan |
| Hong Kong SAR | Tanzania, UR |
| India | Thailand |
| Indonesia | Togo |
| Iran | Tokelau |
| Kazakhstan | Turkmenistan |
| Kenya | Uganda |
| Kiribati | Ukraine |
| Korea, DPR | Uzbekistan |
| Korea Rep. | Vanuatu |
| Kyrgyzstan | Vietnam |
| Lao PDR | Yemen |
| Latvia | Zambia |
| Lesotho | Zimbabwe |
| Liberia | |

Please have your health care provider complete the other side of this form.

