

YOU HAVE BEEN ACCEPTED. Information you provide will not be used to influence your situation at the College; it will be used, if necessary, solely as an aid to providing necessary health care while you are a student. The information that you provide regarding any disability you may have is voluntary.

Return to:
College Health Center
College of Mount Saint Vincent
6301 Riverdale Avenue
Riverdale, NY 10471

Student ID #
This information is strictly for the use of the professional staff of the College and will not be released to anyone without your knowledge and consent.

REPORT OF MEDICAL HISTORY

PLEASE COMPLETE THIS PAGE BEFORE you go to your PHYSICIAN or N. P. for your EXAMINATION.

SEX: M F

LAST NAME (Print) FIRST NAME MIDDLE

HOME ADDRESS (Number and Street) CITY or TOWN STATE ZIP CODE DATE OF BIRTH

NAME, RELATIONSHIP AND ADDRESS OF NEXT OF KIN HOME TELEPHONE NUMBER

NEXT OF KIN'S BUSINESS ADDRESS BUSINESS TELEPHONE

LIST OF COLLEGES YOU HAVE ATTENDED; ADDRESSES AND DATES CITIZENSHIP

ARE YOU A VETERAN? BRANCH AND LENGTH OF SERVICE S M OTHER MARITAL STATUS CLASS YOU ARE ENTERING

Family History

	Age	State of Health	Occupation	Age of Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Have any of your **RELATIVES** ever had any of the following?

	Yes	No	Relationship
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
Cardiac Arrest at young age			
Unknown Cause of Death			
Asthma or Hay Fever			
Epilepsy or Seizures			
Marfan Syndrome			

STUDENT'S PERSONAL HISTORY - PLEASE ANSWER ALL QUESTIONS.

Comment on all positive answers in space below or on additional sheet.

HAVE YOU HAD?	Yes	No		Yes	No		Yes	No		Yes	No
Chicken Pox			Pain or Pressure in Chest			Disease or Injury of Joints			Dizziness or Fainting		
Frequent Anxiety			Chronic Cough			"Trick" Knee			Weakness or Paralysis		
Frequent Depression			Palpitations (Heart)			Shoulder			Diabetes		
Frequent Headache			High Blood Pressure			Back Problems			Albumin / Sugar in Urine		
Frequent Diarrhea			Low Blood Pressure			Head Injury			Frequent Urination		
Malaria			Sinusitis			with unconsciousness			Hepatitis		
Measles			Shortness of Breath			Recent gain of weight			Jaundice		
Mumps			Asthma			Recent loss of weight			Epilepsy		
Rheumatic Fever			Insomnia			Tuberculosis Disease			Seizures		
Problem with:			Worry or Nervousness			ALLERGY			Tumor or Cyst		
Ear, Nose, Throat			Heart Murmur			Environmental			Cancer		
Eyes			Surgery			Foods (name)			FEMALES ONLY		
Gall Bladder			Appendectomy			Penicillin			Irregular Periods		
Intestinal			Hernia Repair			Sulfur			Severe Cramps		
Migraine Headache			Tonsillectomy			Other Medications (name)			Personality Changes		
Stomach			Other						PMS		
Other											

REMARKS OR ADDITIONAL INFORMATION
(Use additional sheet if necessary)

Student's Signature

Physician or N. P.'s Signature

TO THE EXAMINING M.D. or N.P.: Please review the student's history and complete this form. 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 it is necessary. This information is strictly for the use of the professional staff of the College and will not be released without student consent.

Print: last name _____ first name _____ date of birth _____

Vision: Right 20/____ Left 20/____ **Corrected Vision:** Right 20/____ Left 20/____

BP _____ / _____ **Pulse at rest** _____ **Pulse 1 minute after exercise** _____

Height _____ **Weight** _____ lbs.

**** DO THE T.B. Test WITH THIS EXAM:**

DATE of I.P.P.D Tuberculin Test: _____

Result: _____ mm

Negative _____

Positive _____

CHEST X-ray (if Positive)

Date of Chest X-ray _____

Result of Chest X-ray _____

Student receiving therapy _____

Therapy not required _____

URINALYSIS:

Blood _____ **Leucocytes** _____

Glucose _____ **Protein** _____

IMMUNIZATION DATES:

Tdap _____

Tetanus/Diphtheria _____

(NYS recommended vaccines for college students:)

Hepatitis B 1) _____

2) _____

3) _____

Meningococcal Vaccine:

Required for all Resident / Dorm Students

Menomune _____

OR Menactra _____

NOTE: A Meningococcal Meningitis Vaccination

Response Form must be signed and on file

in the Health Center for each Student.

Flu Vaccine(s): List Vaccine Type & Date Given

Vaccine _____ **Date** _____

Vaccine _____ **Date** _____

ABNORMALITIES

	YES	NO
Cardiovascular		
Eyes		
Gastrointestinal		
Genitourinary		
Head, Ears, Nose or Throat		
Metabolic/Endocrine		
Musculoskeletal		
Neuropsychiatric		
Respiratory		
Skin		

Is there **loss or seriously impaired function** of any organ? _____ Yes _____ No

Can the student play on an intercollegiate team? _____ Yes _____ No

Recommendations for physical activity (P.E., Intramurals) _____ Unlimited _____ Limited

Do you have any **recommendations** regarding the care of this student? _____ Yes _____ No

Explain:

Is student now under treatment for any medical or emotional condition? _____ Yes _____ No

Explain:

PHYSICIAN OR NP's SIGNATURE: _____

PRINT PHYSICIAN'S or NP's LAST NAME: _____

ADDRESS (use Stamper) _____

_____ Date of physical exam

_____ Date form signed