Health History & Physical Examination Form

DUE DATE: AUGUST 1ST (FALL SEMESTER) JANUARY 1ST (SPRING SEMESTER)

SUNY POLYTECHNIC INSTITUTE

SUNY Poly
Wellness Center
100 Seymour Road
Utica, NY 13502
Phone: 315.792.7172
Fax: 315.792.7371

1. **According to NYS Public 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 the college.**
2. **All incoming full time students must provide the Wellness Center a physical exam & health history completed by a MD, NP or PA within the last 2 years. Failure to provide will result in an academic hold, prohibiting access to your student account, obtain grades, or register for additional courses. ALL Department of Nursing students are required to use this form for medical documentation submission. ☐ Check here if you are a Department of Nursing student ALL Intercollegiate athletes must have a physical exam within 6 months of their sport start date; including non-traditional season. Contact respective departments with questions.**
3. **Confidential Form. Information is for use at the SUNY Poly Wellness Center only and will not be released without the student's written consent, or a court order.**

Please Print

SUNY Poly ID #: U____________________

Name ____
Last First Middle

Home address ____

Local address (if known) ______________________________

Home phone (____)________________ Cell phone (_____)______________

Birth date: ____ ____ - ____ ____ - ____ ____ ____ ____ Age: ____________

Gender: __________________

Race:
☐ Caucasian ☐ Black/ African American ☐ Hispanic/ Latino
☐ Native American ☐ Asian/Pacific Islander
☐ Prefer not to answer ☐ Other _____________

Emergency Contact Information — REQUIRED

Name ____

Address ____

Home phone (_____)________________ Cell phone (_____)____ ______

Business phone (_____)______________ Relationship ____________________

College Related Information

Major: ____________________________________

Entering term: ☐ Fall ☐ Spring Year ________

Year expected to graduate: _____________

☐ First Year ☐ Sophomore
☐ Junior ☐ Senior ☐ Graduate

Current Health Care Provider (MD, NP or PA)

Name ____

Address ____

Phone (_____)__________________________

Health Insurance

SUNY Poly requires all domestic students comply with health insurance regulations as federally mandated by the Affordable Care Act. This law requires that all individuals have health insurance.

SUNY requires all international students entering the country for study or research to purchase a SUNY health insurance policy. Students are enrolled and billed automatically.

ALL MEDICAL INFORMATION IS CONFIDENTIAL

Consent for Medical Care: ALL registered students **AND** parent/guardian of students *under 18 years of age* **MUST** sign.

I hereby give permission to the SUNY Poly medical/nursing staff to examine and treat (Student's name)____________________________ for all medical problems/injuries while he/she is at SUNY Poly. In the event of time restraints, or that I cannot be reached, I hereby give permission for the Wellness Center staff to secure consultative care that may include hospitalization, anesthesia, surgery and/ or other medical treatment. I also give permission for the SUNY Poly medical/nursing staff to share pertinent health information with the SUNY Poly Counseling and Disability Services staff as deemed necessary. I understand that I have the right to revoke this consent at any time.

____________________________________ **AND** ____________________________________
Student signature Date Parent/guardian signature IF student is **under** 18 years old Date

Intercollegiate Athletes: I hereby give permission to both the SUNY Poly Wellness Center and Athletics to share pertinent health information between each department for participation in intercollegiate sports. Student signature ______________________________ Date __________

Nursing Students: I hereby give permission to both the SUNY Poly Wellness Center and the Department of Nursing to share pertinent health information between departments for clinical activity. Student signature ______________________________ Date __________

Under 18 years of age? Parent signature required for Intercollegiate Athletes or Nursing Students ___________________________ Date __________

SUNY POLYTECHNIC INSTITUTE

PERSONAL MEDICAL HISTORY

Student Completes

Student Name ______________________________ **Date** ______________

	Yes	No	
Blood Related	☐	☐	Anemia
	☐	☐	Blood disorders /Bleeding trait/Sickle Cell
	☐	☐	HIV/AIDS
	☐	☐	Phlebitis
Cardiac	☐	☐	Dizziness/fainting
	☐	☐	Heart Disease
	☐	☐	High blood pressure
	☐	☐	High cholesterol
	☐	☐	Rheumatic fever
Gastro-Intestinal	☐	☐	Chronic inflammatory bowel disease (Crohn's, ulcerative colitis, etc.)
	☐	☐	Digestive trouble
	☐	☐	Hepatitis
	☐	☐	Peptic ulcer
Mental Health/Emotional			
	☐	☐	ADHD/ADD
	☐	☐	Alcohol or drug use, problem or treatment
	☐	☐	Anxiety or nervousness
	☐	☐	Autism spectrum disorder (Asperger's, etc.)
	☐	☐	Bipolar disorder/manic depression
	☐	☐	Depression
	☐	☐	Eating disorders: bulimia/anorexia nervosa
	☐	☐	PTSD
Neurological	☐	☐	Migraine/recurrent headaches
	☐	☐	Seizure disorder (epilepsy)
	☐	☐	Head Injury/Concussion
Respiratory	☐	☐	Asthma
	☐	☐	Chronic bronchitis/emphysema
	☐	☐	Ear infections/hearing problems
	☐	☐	Hay Fever
	☐	☐	Pneumonia
	☐	☐	Tuberculosis or past positive tuberculin test
	☐	☐	Treatment to prevent tuberculosis or for active tuberculosis
Urinary/Reproductive			
	☐	☐	Breast disease
	☐	☐	Kidney disease (congenital /chronic//other)
	☐	☐	Menstrual problems
	☐	☐	Pregnancy
	☐	☐	Sexually transmitted disease
	☐	☐	Urinary infection
Other	☐	☐	Absence/damage to any paired organ (kidney, eye, etc.)
	☐	☐	Acne (under treatment)
	☐	☐	Arthritis
	☐	☐	Cancer or malignancy
	☐	☐	Cerebral palsy
	☐	☐	Chicken pox
	☐	☐	Diabetes Mellitus
	☐	☐	Fracture/sprains
	☐	☐	Insomnia/sleep problems
	☐	☐	Orthopedic problems/injuries
	☐	☐	Skin disorder
	☐	☐	Systemic lupus
	☐	☐	Thyroid disorder
	☐	☐	Tobacco use
	☐	☐	Other: Explain below

If yes to any of the above, explain: ______________________________

____

____

Have you had any surgery? Explain: ______________________________

____

Have you been hospitalized? ______________________________

Other medical concerns (specify)______________________________

____

ALLERGIES AND OTHER SEVERE ADVERSE REACTIONS:

☐ **NO KNOWN ALLERGIES**

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

____

Please describe allergic reaction: ______________________________

____

Do you use an EpiPen when you have a reaction? ☐ Yes ☐ No

If yes, do you have an EpiPen? ☐ Yes ☐ No

CURRENT MEDICATIONS: frequent or regular - Please list

- ☐ Acne medication ______________
- ☐ Bowel medication ______________
- ☐ ADHD/ADD medication ______________
- ☐ Headache medication ______________
- ☐ Allergy medication ______________
- ☐ Heart rhythm medication ______________
- ☐ Allergy shots ______________
- ☐ Insulin ______________
- ☐ Anti-depressants ______________
- ☐ Over the counter (OTC's) ______________
- ☐ Anxiety medication ______________
- ☐ Pain medication ______________
- ☐ Asthma medication ______________
- ☐ Seizure medication ______________
- ☐ Birth control pills ______________
- ☐ Thyroid medication ______________
- ☐ Blood pressure medication ______________
- ☐ Other: (specify) ______________

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

Parent(s)	Grand-Parent(s)	Sibling(s)	
☐	☐	☐	Alcoholism or drug addiction
☐	☐	☐	Bleeding disorders
☐	☐	☐	Cancer
☐	☐	☐	Heart disease
☐	☐	☐	High blood pressure
☐	☐	☐	Emotional/mental illness
☐	☐	☐	Stroke
☐	☐	☐	Sudden death before 35 years
☐	☐	☐	Other (please specify)

☐ **None of the above**

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PHYSICAL EXAMINATION

Health Care Provider Completes

Student Name ____ **Birth Date** ___ ___-___ ___-___ ___ ___ ___

☐ Female ☐ Male ☐ Other _______	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

Physical Exam Date ____________________

	Normal	Abnormal	Notes/Details
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:

Any issues/concerns that SUNY Poly should be aware of while providing episodic medical care to this college student:

Clearance as a Nursing Student/Health Care Provider ___________Yes ___________No

Clearance as an Intercollegiate Athlete/ Sports Physical Exam ___________Yes ___________No

Comments: ____

____

Examining Health Care Provider Name (Please Print)____

Signature Examining Health Care Provider ______________________________ **Date:** ________________

IMMUNIZATION RECORD

Health Care Provider Completes

Student Name ____ **Birth Date** ___ ___-___ ___-___ ___ ___ ___

	Month/ Day/Year	Initials of certifying health professional	Physician diagnosed disease history (date of onset)	Titers
MMR Combined Vaccine (REQUIREMENTS AS NOTED BELOW) **OR**	#1 #2			Laboratory Report with lab values 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 with numeric result or physician documentation of having the disease are acceptable in lieu of the vaccine.	#1 #2			Laboratory Report with lab values MUST be attached
MUMPS: ONE DOSE REQUIRED If born after 1/1/57, 1 dose LIVE vaccine given AFTER the first birthday. Positive titer with numeric result or physician documentation of having the disease are acceptable in lieu of the vaccine. **Nursing students require 2 doses.**				Laboratory Report with lab values MUST be attached
RUBELLA: ONE DOSE REQUIRED If born after 1/1/57, 1 dose LIVE vaccine given AFTER the first birthday. Positive titer with numeric result is acceptable in lieu of the vaccine. **Nursing students require 2 doses**			**Not Acceptable**	Laboratory Report with lab values MUST be attached
MENINGOCOCCAL MENINGITIS (ACWY only): ONE DOSE REQUIRED **OR** **Completed Meningococcal Meningitis Response Form indicating declination of a Meningococcal Meningitis vaccine** **** Vaccination required within the last five years**			**A SUNY Poly provided Meningococcal Meningitis Response Form** MUST be completed by the student in lieu of the vaccine.	
REQUIRED FOR DEPARTMENT OF NURSING STUDENTS, recommended for all other students:				
TETANUS/DIPTHERIA: Updated with DTaP every 10 years				
VARICELLA: Either 2 vaccines or positive titer with numeric result	#1 #2			Laboratory Report with lab values MUST be attached
HEPATITIS B: Either 3 vaccines or a positive titer with numeric result	#1 #2 #3			Laboratory Report with lab values MUST be attached
ANNUAL INFLUENZA VACCINE				
ANNUAL TUBERCULOSIS TESTING: **Mantoux, QuantiFERON TB-GOLD or T-SPOT** **A positive Mantoux, QuantiFERON TB-GOLD or T-SPOT REQUIRES further testing with documentation.**	**Mantoux: Date Placed**_______ Date Read_________ Results _________ mm **QuantiFERON TB-GOLD or T-Spot: Date** _______ Negative____ Positive ____ **<u>If</u> positive:** Chest X-Ray Date ___________ Results __________ Diagnosis: Latent TB or Active TB Was treatment offered? Yes ______ No ______ Treatment & Date Completed_________________________________			

Signature of Health Care Professional ______________________________________ Date _______________

Return to: SUNY Poly Wellness Center 100 Seymour Road Utica, NY 13502 Fax: 315.792.7371

SD: OF/Front Office /PE 6/19