Health History & Physical Examination Form

SUNY Polytechnic Institute

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

DUE DATE: AUGUST 1ST (FALL SEMESTER) **JANUARY 1ST (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 incoming full time students must provide the Wellness Center a health history physical exam will and physical exam completed by a healthcare provider within the last 2 years. Failure to provide a result in an academic hold, prohibiting your ability to access 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. ALL Intercollegiate athletes must have a physical exam with 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

Student Identification

Name _____
Last First Middle

Home address _____

_____

Local address (if known) _____

Home phone (____)_____ Cell phone (_____)_____

Birth date: ____ ____ - ____ ____ - ____ ____ ____ ____ Age: _____

Gender: ☐ Female ☐ Male ☐ Other _____

Race: ☐ White/Non Hispanic ☐ African American ☐ Native American
☐ Asian ☐ Hispanic ☐ Other _____

Emergency Contact Information

Name _____ _____

Address _____

_____

Home phone (_____)_____ Cell phone (_____)____ _____

Business phone (_____)_____ Relationship _____

College Related Information

Entering term: ☐ Fall ☐ Spring Year _____

Year expected to graduate: _____

☐ Freshman ☐ Sophomore

☐ Junior ☐ Senior ☐ Graduate

Current Health Care Provider (Physician)

Name _____

Address _____

_____

Phone (_____)_____

Medical Insurance

SUNY Poly requires all domestic students taking 12 or more credits & ALL nursing students regardless of credit hours to have medical insurance coverage. **Enrollment and billing is automatic unless you waive the designated SUNY Poly medical insurance your first semester, then each fall semester thereafter.** Once you receive your PIN number you MUST waive the medical insurance electronically.

SUNY requires all international students entering the country for study or research to purchase a SUNY medical 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 other 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 each other for clinical activity. Student signature _____ Date _____

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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	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: **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 ____ **If 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 Wellness Center 100 Seymour Road Utica, NY 13502 Fax: 315.792.7371

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