



Mail or Fax All Forms To:

NJIT – Student Health Services

Estelle & Zoom Fleisher Athletic Center

323 Martin Luther King., Newark, NJ 07102

Website: www.njit.edu/healthservices

Office #: 973-596-3621 – Fax #: 973-596-5517

E-mail: healthservices@njit.edu

HEALTH HISTORY QUESTIONNAIRE PHYSICAL EXAMINATION

TO THE STUDENT: This information is required that NJIT Student Health Services can provide care based on our particular needs. This form becomes a part of your student health record. It as well as any other health care information obtained while you are at NJIT, are confidential and will not be released to anyone without your written permission. These records must be submitted prior to or the day of registration to Health Services. If your records are not submitted within this time, a **HOLD** will be placed on your future registration until you provide us with your records.

FULL TIME STUDENT REQUIREMENTS:

Tuberculosis Test within the past 6 months

of your registration (*test result is needed*)

Measles (*Proof of two doses*) after your 1st birthday

Mumps (*Proof of two doses*) after your 1st birthday

Rubella (*Proof of two doses*) after your 1st birthday

Or a serology test for Mumps, Measles, and Rubella

(*a lab report is needed*)

Physical Exam, by a physician (*within the past 6*

month of your registration)

Hepatitis B – Proof of 3 doses or lab evidence of immunity

Varicella (Chickenpox) (*Proof of two doses*) or lab

evidence of immunity.

PART-TIME STUDENT REQUIREMENTS

Same as full-time Student/No Physical Exam

MENINGITIS VACCINE - Required for **ALL** Students

AGE EXEMPT REQUIREMENTS

Those born before 1957 are required to submit blood test (IgG)

to document immunity to Measles, Mumps, or Rubella.

It is suggested that you also be tested for immunity to

Varicella (Chickenpox). You do need to submit documentation

of all other requirements.

Check The Following: Undergraduate _____ Graduate _____ Full-Time _____ Part-Time _____

Name: _____ Date of Birth: ____/____/____

(Last)

(First)

(MI)

NJIT I.D. # _____ Phone #: () _____ E-mail: _____

Address: _____

(Street)

(City)

(State/Country)

(Zip Code)

Campus or Local Address: _____

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY

Name: _____

(Last)

(First)

(MI)

(Street)

(City)

(State)

(Zip Code)

Phone Number: ()- _____ E-Mail Address: _____

TO PARENTS AND GUARDIAN OF STUDENTS UNDER 18 YEARS OF AGE

I authorize the personnel of NJIT Health Services or authorized personnel of the University to proceed according to good medical practice in providing medical care of treatment to my child in an emergency or when unable to reach me for authorization.

Parent/Guardian's Signature: _____ Relationship: _____ Date: ____/____/____

PERSONAL HEALTH ASSESSMENT: For the following questions, please check yes if you are presently having a problem or have had a problem in the past. If there is no significant problem, check no. Briefly explain all yes answers.
TO BE COMPLETED BY STUDENT.

Drug Usage:

Please give information about drug usage
 alcohol, marijuana, smoking.....

Yes No

☐ ☐

Cardiovascular:

Heart murmur/palpitations.....
 Chest Pain.....
 Rheumatic fever.....
 High blood pressure.....
 Irregular heartbeat.....
 Blood clots (not menstrual clots).....
 Enlarge heart.....

☐ ☐
☐ ☐
☐ ☐
☐ ☐
☐ ☐
☐ ☐
☐ ☐

Respiratory:

Asthma.....
 Chest infection.....
 Do you smoke cigarettes?.....
 How many?_____How Long?_____
 Shortness of breath.....
 Wheezing.....

☐ ☐
☐ ☐
☐ ☐
☐ ☐
☐ ☐
☐ ☐

Skin:

Any problems with your skin?.....
 Skin rashes.....

☐ ☐
☐ ☐

Endocrine:

Thyroid disease.....
 Diabetes.....

☐ ☐
☐ ☐

Urinary:

Impaired function of any part of your
 Urinary tract or loss of a kidney

☐ ☐

Kidney Stones:

☐ ☐

Mental Health:

Any problems with your emotional health,
 requiring any form of therapy, including
 medications?.....

☐ ☐

Have you ever experienced a serious
 dietary problem (anorexia, bulimia, obesity)

☐ ☐

Medications:

(birth control pills, vitamins, over-the counter-
 medications and prescriptions):

☐ ☐

Amount:_____
 Usage Per day:_____

Past Illness:

Malaria, Hepatitis, mononucleosis, Chicken pox and
 other childhood diseases
 Loss or absence of any body parts.
 Severe/frequent colds or flu.....

Yes No

☐ ☐
☐ ☐
☐ ☐

Hospitalization:

Have you ever been admitted to a
 hospital?.....
 Have you ever had surgery?.....

☐ ☐
☐ ☐

EENT:

Any problems with your eyes, ears, nose, or
 throat.....
 Hearing impairment.....
 Loss of eye or eyesight.....

☐ ☐
☐ ☐
☐ ☐

Blood:

Anemia.....
 Sickle-cell disease.....
 Abnormal bleeding or bruising.....

☐ ☐
☐ ☐
☐ ☐

Bone and Joint:

Any serious disability deformity or
 disease of bone, joint, or muscle?.....

☐ ☐

Neurology:

Seizures or convulsions.....
 Fainting or blackouts.....
 Dizziness.....

☐ ☐
☐ ☐
☐ ☐

Gastrointestinal:

Problems with any part of your intestinal
 tract or stomach?.....
 Jaundice.....
 Hernia.....

☐ ☐
☐ ☐
☐ ☐
☐ ☐

Reproductive System (men):

Prostate trouble.....
 Swelling of the scrotum or testicle.....
 Undescended or absent testicle.....
 Do you perform testicular self-
 examination?.....

☐ ☐
☐ ☐
☐ ☐
☐ ☐

Reproductive System (women):

Never had a menstrual period?.....
 Any form of menstrual disorder?.....
 Do you perform breast self-exam.....
 Last menstrual period_____

☐ ☐
☐ ☐
☐ ☐

Allergy:

Any significant allergy to food, medications, insects, pollen?.....

Food?

Other?

Yes**No**☐☐☐☐☐☐**Family History:**

Age and Health, if living, or Cause of Death:

Father:

Mother:

Brother:

Sisters:

Check the following diseases that have appeared among parents, grandparents, and siblings:

☐ Tuberculosis☐ Kidney disease☐ Diabetes☐ Emotional illness☐ Cancer (type)☐ High blood pressure☐ Seizure disorder☐ Problems with alcohol/drugs☐ Stroke☐ Asthma☐ Heart disease☐ Other**Comments:****To The Student:**

I certify that the statements in Section I & II are true to the best of my knowledge, and I consent to treatment in the Student Health Services with the understanding that all services rendered are confidential.

Student Signature: _____ Date: ____/____/____

NJIT PHYSICAL EXAMINATION

(Completed by physician)

TO THE PHYSICIAN: Please review the student's personal history and complete the form below. Comment on all abnormal findings. This student has been accepted at New Jersey Institute of Technology and this information will note his/her medical status. It will be used only as a background for providing health care. This information is strictly for the use of the Health Services and will not be released without the written permission of the students.

Name: _____ Date of Birth: ____/____/____

(Last)

(First)

(MI)

Height: _____ Weight _____ BP _____ Pulse _____

Vision: Uncorrected Right _____ Left _____ Corrected Right _____ Left _____

ASSESSMENT:

	Normal	Abnormal
1. Eyes	_____	_____
2. Ears	_____	_____
3. Nose, throat	_____	_____
4. Neck/thyroid	_____	_____
5. Chest, lungs	_____	_____
6. Cardiovascular	_____	_____
7. Abdomen, liver, spleen	_____	_____
8. Genitalia, hernia	_____	_____
9. Nervous system, balance	_____	_____
10. Skin	_____	_____
11. Musculoskeletal	_____	_____
Upper extremity: AC joints, shoulder stability, symmetry, range of motion	_____	_____
Spine: Neck-ROM, forward bend, curve	_____	_____
Lower extremity: range of motion, symmetry	_____	_____
Ligaments, gait, knees, ankles	_____	_____
12. Psychological	_____	_____
13. Other	_____	_____

ABNORMAL FINDINGS:

COMMENTS: Recommendations, continuing treatment, restrictions:

I have reviewed the clinical history as given by the student and after performing a physical exam, I certify that this student is able to participate in physical education and intramural activities without restrictions.

May _____ May not _____ Participation In _____
(Name of Sport)

Examiner's Signature _____ Date ____/____/____

Print Name _____ Phone # _____

Address _____
(Street) (City) (State) (Zip Code)