

Health History & Physical Examination Form

SUNY POLYTECHNIC
INSTITUTE

SUNY Poly
Health & 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 Health & Wellness Center a health history and physical exam completed by a healthcare provider within the last 2 years. Failure to provide a physical exam will 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 within 6 months of their sport start date; including non-traditional season. Contact the respective departments with questions.**
3. **Confidential Form.** Information is for use at the SUNY Poly Health & 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 Health & 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 Health & 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 Health & Wellness Center and the Department of Nursing to share pertinent health information between each other for clinical activity. Student signature _____ Date _____

Student Name _____

Date _____

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

- | | |
|--|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Insect/bee sting |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Lidocaine/xylocaine |
| <input type="checkbox"/> X-ray contrast | <input type="checkbox"/> Food |
| <input type="checkbox"/> 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

- | | |
|--|---|
| <input type="checkbox"/> Acne medication | <input type="checkbox"/> Bowel medication |
| <input type="checkbox"/> ADHD/ADD medication | <input type="checkbox"/> Headache medication |
| <input type="checkbox"/> Allergy medication | <input type="checkbox"/> Heart rhythm medication |
| <input type="checkbox"/> Allergy shots | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Anti-depressants | <input type="checkbox"/> Over the counter (OTC's) |
| <input type="checkbox"/> Anxiety medication | <input type="checkbox"/> Pain medication |
| <input type="checkbox"/> Asthma medication | <input type="checkbox"/> Seizure medication |
| <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Thyroid medication |
| <input type="checkbox"/> Blood pressure medication | <input type="checkbox"/> 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)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism or drug addiction
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emotional/mental illness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sudden death before 35 years
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify)

☐ **None of the above**

Student Name _____ Birth Date _____ - _____ - _____

<input type="checkbox"/> Female <input type="checkbox"/> 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 _____

	<u>Normal</u>	<u>Abnormal</u>	<u>Notes/Details</u>
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			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/DIPHTHERIA: 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 Poly Health & Wellness Center 100 Seymour Road Utica, NY 13502 Fax: 315.792.7371

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