



MEDICAL HISTORY

PLEASE COMPLETE BEFORE YOUR PHYSICAL EXAMINATION (PLEASE PRINT):

NAME (LAST, FIRST, MIDDLE) \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
TELEPHONE # \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

FAMILY MEMBER TO NOTIFY IN EMERGENCY: NAME _____ TELEPHONE # _____	PERSONAL PHYSICIAN OR CLINIC: NAME _____ TELEPHONE # _____
PERSON OUTSIDE FAMILY TO NOTIFY IN EMERGENCY: NAME _____ TELEPHONE # _____	HEALTH INSURANCE: _____ POLICY CERT/GROUP #: _____

MARK AN "X" IF YOU HAVE HAD OR HAVE BEEN TREATED FOR THE FOLLOWING:

- ALCOHOL DEPENDENCE OR OTHER PROBLEMS
- ANEMIA
- ARTHRITIS
- ASTHMA
- BRONCHITIS
- CANCER
- CEREBRAL PALSY
- CHICKEN POX
- CHRONIC INTESTINAL PROBLEMS
- DEPRESSION
- DIABETES
- DRUG DEPENDENCE
- EATING DISORDERS
- ECZEMA
- EPILEPSY
- EMOTIONAL PROBLEMS
- FREQUENT COLDS
- GERMAN MEASLES
- HAY FEVER
- HEPATITIS
- HEARING PROBLEMS
- HEART PROBLEMS (CONGENITAL OR OTHER)
- HIVES
- INFECTIOUS MONONUCLEOSIS
- KIDNEY DISEASE
- MALARIA
- MEASLES
- MULTIPLE SCLEROSIS
- MUMPS
- OPERATIONS—SURGERY (EXPLAIN BELOW\*)
- ORTHOPEDIC PROBLEMS
- PNEUMONIA
- POLIO
- SCARLET FEVER
- SINUSITIS
- SPEECH DEFECTS
  - TONSILLITIS
  - TUBERCULOSIS OR TB CONTACT
- TYPHOID FEVER
- VISION PROBLEMS OTHER THAN CORRECTIVE LENSES
  - WHOOPING COUGH
- RHEUMATOID HEART DISEASE

\*SURGERY EXPLANATION \_\_\_\_\_

LIST ALLERGIES (FOOD, DRUG, ETC.) \_\_\_\_\_

LIST MEDICATIONS TAKEN REGULARLY \_\_\_\_\_

LIST COMMON FAMILY DISEASES (CANCER, HEART, ETC.) \_\_\_\_\_

LIST ANY PERMANENT PHYSICAL DISABILITY \_\_\_\_\_

REMARKS OR OTHER COMMENTS \_\_\_\_\_

STUDENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
(ACKNOWLEDGING REVIEW)

# PHYSICAL AND IMMUNIZATION RECORD FOR VILLA MARIA COLLEGE OF BUFFALO

**TO THE EXAMINING PHYSICIAN:** Review the student's medical history and complete the physical section and immunization record on this side of form. This student has been accepted. The information will not affect his/her status—it will be used only as a background for providing health care if necessary. This information is strictly for the use of Health Services and will not be released without student consent.

## PART I—PHYSICAL

STUDENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_ PULSE \_\_\_\_\_ TEMPERATURE \_\_\_\_\_

**CLINICAL EVALUATIONS:** Are there any abnormalities of the following? Describe fully. (Use reverse side if necessary.)

	Yes	No		Yes	No
Head, Neck, Face, Scalp	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Nose, Sinuses	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Mouth, Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Teeth, Gingiva	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Lungs, Chest	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
			Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
			Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
			Spine, Musculo-Skeletal	<input type="checkbox"/>	<input type="checkbox"/>
			Extremities	<input type="checkbox"/>	<input type="checkbox"/>
			Skin	<input type="checkbox"/>	<input type="checkbox"/>
			Neurological	<input type="checkbox"/>	<input type="checkbox"/>
			Genitalia	<input type="checkbox"/>	<input type="checkbox"/>

Describe any limitation of physical activity: \_\_\_\_\_

Considering the history and physical exam, in your opinion is this student able to meet the demands of college life?  YES  NO

Do you recommend further investigation or treatment? \_\_\_\_\_

## PART II—IMMUNIZATION RECORD

**A. M.M.R. (Measles, Mumps, Rubella)** (Two doses required.)

1. Dose 1 given at age 12-15 months or later .....#1 \_\_\_\_\_ / \_\_\_\_\_  
M Y

2. Dose 2 given at age 4-6 years or later, and at least one month after first dose .....#2 \_\_\_\_\_ / \_\_\_\_\_  
M Y

**B. TETANUS-DIPHTHERIA** (Primary series with DtaP or DTP and booster with Td in the last ten years meets requirement. Refer to ACIP for details.)

1. Primary series of four doses with DTaP or DTP:

#1 \_\_\_\_\_ / \_\_\_\_\_ #2 \_\_\_\_\_ / \_\_\_\_\_ #3 \_\_\_\_\_ / \_\_\_\_\_ #4 \_\_\_\_\_ / \_\_\_\_\_  
M Y M Y M Y M Y

2. Tetanus-Diphtheria (Td) booster within the last ten years ..... \_\_\_\_\_ / \_\_\_\_\_  
M Y

**C. HEPATITIS B** (Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a positive Hepatitis B surface antibody meets the requirement).

**1. Immunization (Hepatitis B)**

Dose #1 \_\_\_\_\_ / \_\_\_\_\_ Dose #2 \_\_\_\_\_ / \_\_\_\_\_ Dose #3 \_\_\_\_\_ / \_\_\_\_\_  
M Y M Y M Y

**2. Immunization (Combined Hepatitis A and B Vaccine)**

Dose #1 \_\_\_\_\_ / \_\_\_\_\_ Dose #2 \_\_\_\_\_ / \_\_\_\_\_ Dose #3 \_\_\_\_\_ / \_\_\_\_\_  
M Y M Y M Y

**3. Hepatitis B Surface Antibody** Date \_\_\_\_\_ / \_\_\_\_\_ Result: Reactive \_\_\_\_\_ Non-reactive \_\_\_\_\_  
M Y

**D. TUBERCULIN SKIN TEST**

Tine or Patch: Negative \_\_\_\_\_ Positive \_\_\_\_\_ Degree of Induration \_\_\_\_\_ Date: \_\_\_\_\_  
*(TB must be within the last six months.)*

SIGNATURE OF PHYSICIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

PLEASE PRINT PHYSICIAN'S NAME, ADDRESS, AND TELEPHONE NUMBER: \_\_\_\_\_

