



MEDICAL HISTORY REPORT

To the Student: Information you submit is used solely as an aid to providing necessary health care while you are a student. This information is strictly for the use of Decker Student Health Services and may not be released to anyone without your written consent.

Decker Student Health Services Center
PO Box 6000
Binghamton, New York 13902-6000
607-777-2221, Fax: 607-777-2881
www2.binghamton.edu/health

Please indicate your date of entrance: 20__ Fall Spring Summer
Entering as: Full time Part time
Have you previously attended Binghamton University? Yes No If yes, when?____ Freshman/Undergraduate Transfer/Undergraduate Graduate

STUDENTS SHOULD COMPLETE THIS PART OF FORM BEFORE GOING TO THE PHYSICIAN FOR EXAMINATION.

PLEASE PRINT IN BLACK INK

BU Student ID # _____

Name: Last _____ First _____ Middle _____ Birth date ____/____/____ MO. DAY YR. Gender: M F
Home address _____ Home phone (____) _____
City _____ State or Country _____ ZIP _____ Cell phone (____) _____
Health insurance that will be used while in school (if known) _____ Policy number (if known) _____
Emergency contact _____ Relationship _____
Emergency contact address (if different from above) _____
Emergency contact phone (____) _____ Work (____) _____ Cell (____) _____

FAMILY HISTORY

	Age	State of health	Occupation	Age at death	Cause of death
Father					
Mother					
Brothers					
Sisters					

Have any of your relatives ever had any of the following?

	Yes	No	Relationship
Arthritis			
Asthma, Hay Fever			
Cancer			
Diabetes			
Epilepsy, Convulsions			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Stomach Disease			
Tuberculosis			

PERSONAL HISTORY – PLEASE ANSWER ALL QUESTIONS. Comment on all POSITIVE answers in space below.

Have you had:	Yes	No	Don't Know	Have you had:	Yes	No	Don't Know	Have you had:	Yes	No	Don't Know	Have you had:	Yes	No	Don't Know
Allergy:				Diarrhea (recurrent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disease or Injury of Joints, Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfonamides	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness, Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, Cancer, Cyst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Problems:				Respiratory Problems:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Problems:			
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety (frequent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Albumin/Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food (which) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression (frequent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough (chronic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear, Nose, Throat Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicable Diseases:				Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakness, Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder/Gallstone Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain or Loss (recent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Measles (rubeola)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Females Only:			
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury with Unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rubella (German measles)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches (frequent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease or Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or Intestinal Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia, Rupture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												

REMARKS OR ADDITIONAL INFORMATION (Please list any routine medications.)

Has your physical activity been restricted during the past five years? (Give reasons and durations.) Yes No
Have you received treatment or counseling for a nervous condition, personality or character disorder or emotional problem? (Give details.) Yes No
Have you consulted or been treated by clinics, physicians, healers or other practitioners within the last five years? (Other than routine checkups?) Yes No
Have you used any tobacco products within the past 30 days? Yes No
Do you use alcohol, marijuana or other drugs? Yes No

X _____
Student's signature Date

Name: Last _____ First _____ Middle _____ Birth date: Mo. _____ Day _____ Yr. _____

PART A MUST BE SIGNED BY STUDENT (OR PARENT/GUARDIAN) AND PART C MUST BE SIGNED BY A HEALTHCARE PROVIDER.

MANDATORY

PART A: MENINGITIS INFORMATION — Must be completed and signed by ALL students regardless of age or registration status

I have (or for students under 18, my child has) (Please check one):

____ had the meningococcal immunization (Menomune®) within the past 10 years

____ read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will **not** obtain immunization against meningococcal meningitis disease. I understand that I may choose to seek vaccination in the future. The vaccine is available at the Decker Student Health Services Center for a fee and may also be available from community health providers or county health departments.

Signature of student (or parent/guardian if under 18) _____ Date _____

PART B: PHYSICAL EXAMINATION — Strongly recommended to assist the Health Service in delivering care and provide opportunity to update vaccinations and review issues including risk behaviors, sexuality, cigarette, alcohol and other drug use.

Date of physical exam ____/____/____ MO. DAY YR. Blood pressure _____ Height _____ Weight _____ Vision: Right 20/____ Left 20/____
 corrected uncorrected

RECOMMENDED		Normal	Abn.	Explanation
	Head, Ears, Nose, Throat			
	Respiratory			
	Cardiovascular			
	Gastrointestinal			
	Hernia			
	Eyes			
	Genitourinary			
	Musculoskeletal			
	Metabolic/Endocrine			
	Neuropsychiatric			
Skin				

Is the patient now under treatment for any medical or emotional condition? Yes _____ No _____

Are there any restrictions on physical activity related to classes or sports? Yes _____ No _____

Please comment on any "yes" answers _____

_____ **Optional** _____

Hemoglobin and/ or hematocrit Numerical values _____ Normal _____

Urine dipstick: Normal _____ Abnormal _____

PART C: IMMUNIZATION RECORD — MUST BE SUBMITTED BY ALL STUDENTS BORN ON OR AFTER JAN. 1, 1957

	IMMUNIZATION	Date vaccine given: Mo./Day/Yr.		Serology date	Immune		Physician diagnosed disease/ date of onset
		#1	#2		Yes	No	
MANDATORY	MMR combined (2 doses)	#1	#2	N/A	N/A	N/A	
	OR { Measles (2 doses live vaccine on or after first birthday and after 1967) and Mumps (1 dose of live vaccine on or after first birthday) and Rubella (1 dose of live vaccine on or after first birthday)	#1	#2				
RECOMMENDED	Hepatitis A	#1	#2	Serology date and results _____			Physician diagnosed disease/date of onset _____
	Varicella (Chickenpox)	#1	#2	Serology date and results _____			Physician diagnosed disease/date of onset _____
	Hepatitis B	#1	#2	#3	Serology date and results _____	N/A	
	HPV vaccine	#1	#2	#3	N/A		
	Tetanus/Diphtheria/Pertussis (within 10 years)	Td given ____/____/____ MO. DAY YR. or Tdap given ____/____/____ MO. DAY YR.					
	Meningococcal vaccine	Menactra given ____/____/____ MO. DAY YR. or Menomune given ____/____/____ MO. DAY YR.					

This section or an additional official immunization record must be signed by a healthcare provider.

Examiner's signature _____ Date _____

Print name and title _____

Address _____ Telephone _____

(Collaborating MD name if NP/PA) _____ Registration # and state _____

PART D: TUBERCULOSIS RISK ASSESSMENT REQUIRED — SEE TUBERCULOSIS SCREENING FORM 3