COLLEGE OF
MOUNT SAINT VINCENT

HEALTH CENTER
6301 Riverdale Avenue, Riverdale NY 10471
Phone: 718.405.3240 FAX: 718.405.3737

Student's Name_____ _____/_____/_____
(PRINT) LAST NAME FIRST NAME DATE OF BIRTH

Student's Cell Phone _____ Home Phone _____ CMSV ID _____

Name of next of kin_____ Relationship_____

Address _____ Phone _____

# PHYSICAL EXAMINATION FORM

**PERSONAL HISTORY** Do you have now or have you ever had any of the following? Please check all that apply.

| | | | |
|---|---|---|---|
| 1. ☐ Anemia | 10. ☐ Deaf/Hearing impairment | 19. ☐ Injury / Disease of Bones | 28. ☐ Sinusitis |
| 2. ☐ Anorexia / Bulimia | 11. ☐ Depression | 20. ☐ Kidney Disease | 29. ☐ Strep Throat |
| 3. ☐ Anxiety | 12. ☐ Diabetes | 21. ☐ Lupus / SLE | 30. ☐ Surgery |
| 4. ☐ Asthma | 13. ☐ Emotional/Mental Illness | 22. ☐ Migraines / Headaches | 31. ☐ Thyroid Disease |
| 5. ☐ Blind/visual impairment | 14. ☐ Heart Murmur/ Palpitations | 23. ☐ Neuromuscular Disease | 32. ☐ TB Disease |
| 6. ☐ Cancer / malignancy | 15. ☐ Hepatitis | 24. ☐ Phlebitis / Deep Vein Clot | 33. ☐ Ulcer / Stomach |
| 7. ☐ Celiac Disease | 16. ☐ High/Low Blood Pressure | 25. ☐ Positive TB Test | 34. ☐ Unconsciousness |
| 8. ☐ Chest pain / pressure | 17. ☐ High Cholesterol | 26. ☐ Seizure disorder | 35. ☐ Weakness |
| 9. ☐ Cystic fibrosis | 18. ☐ Impaired mobility / paralysis | 27. ☐ Sickle Cell Disease / Trait | 36. ☐ Other_____ |

**PLEASE EXPLAIN ALL POSITIVE ANSWERS (with dates):** _____

**CURRENT MEDICATIONS:** ***List:***_____

**ALLERGY: TO MEDICATION:** ☐ **Penicillin** ☐ **Sulfur** ☐ **Other Medication (name)**_____

☐ **ENVIRONMENTAL** ☐ **FOODS (name)**_____

**EPI-PEN: HAVE YOU EVER NEEDED IT?** ☐ **YES** ☐ **NO** **DO YOU CARRY EPI-PEN?** ☐ **YES** ☐ **NO**

| | Age | State of Health | Occupation | Living | Age of Death | Cause of Death |
|---|---|---|---|---|---|---|
| **Father** | | | | | | |
| **Mother** | | | | | | |
| **Brothers** | | | | | | |
| | | | | | | |
| | | | | | | |
| **Sisters** | | | | | | |
| | | | | | | |
| | | | | | | |

**FAMILY HISTORY:** ***List*** **family members with health problems: i.e. cancer, diabetes, heart disease, Marfan Syndrome,**

_____

_____

**Student's Name**_____ _____/_____/_____
(PRINT) LAST NAME FIRST NAME DATE OF BIRTH

**Vision: R 20/_____ L 20/_____** **Corrected Vision: R 20/_____ L 20/_____**

**Height:_____ Weight:_____** **BP:_____ Pulse:_____**

**Tuberculosis Test: PPD**

Date placed: _____/_____/_____

Date read: _____/_____/_____

Result: _____mm. induration

**Urinalysis:**

Glucose____ Protein_____

Leucocytes_____Blood_____

**Chest X-ray (if PPD Positive) attach typed X-ray copy**

Date of Chest X-ray _____

Result of Chest X-ray _____

Student receiving therapy:_____

☐ Yes ☐ No ☐ Refused

**Immunization Dates:**

. Tdap _____

Td _____

*Attach Immunization record for other Vaccines received*

| REVIEW | NORMAL | DESCRIBE ABNORMALITY |
|---|---|---|
| Anemia (type) | | |
| Cardiovascular | | |
| Chest and Breasts | | |
| Gastrointestinal | | |
| Genitourinary | | |
| HEENT | | |
| Metabolic / Endocrine | | |
| Musculoskeletal | | |
| Neurological | | |
| Psychological | | |
| Respiratory | | |
| Skin | | |

**CURRENT & CHRONIC PROBLEMS:** _____

_____

**PLEASE ATTACH ADDITIONAL CLINICAL REPORTS TO ASSIST US IN PROVIDING CONTINUITY OF CARE.**

**RECOMMENDATIONS FOR PHYSICAL ACTIVITY:** ☐ Unlimited ☐ Limited (specify):_____

PHYSICIAN OR NP's SIGNATURE: _____

PRINT PHYSICIAN or NP's NAME: _____

State / License #_____ Date of Physical Exam:_____

Address_____ Date Form Signed: _____

Use Office Stamp:

MAIL COMPLETED FORM TO:
COLLEGE OF
MOUNT SAINT VINCENT
**Health Center**
6301 Riverdale Avenue
Riverdale NY 10471

Rev 4/2016