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)**_____

ALLERGY: ☐ **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,**

_____

_____

Please see other side for Physical Exam Report to be completed by MD or NP

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 copy of X-ray

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 if present)		
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

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