

# Report of Medical History

Family Name (Print)	First Name	Middle	Social Security #	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Home Address (Number & Street)	City or Town	State	Zip Code	Date of Birth
E-mail Address	RIN (Rensselaer ID Number)			
				( )
Name, Relationship, and Address of Next of Kin				Home Telephone Number
				( )
Next of Kin's Business Address				Business Telephone
Semester you will begin at Rensselaer: <input type="checkbox"/> Fall <input type="checkbox"/> Spring <input type="checkbox"/> Summer Year _____				<input type="checkbox"/> Freshman <input type="checkbox"/> Transfer <input type="checkbox"/> Graduate
Were you previously a student at Rensselaer? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what year? _____				
Do you plan on participating in intercollegiate sports? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, sport(s) _____				

**1. These medical data are confidential medical information that will not be released to anyone without your consent.** If you are under 18 years of age, your parents may have access to some of the data in your medical and counseling records; they will be notified in the event that you are hospitalized. If you are 18 or over, it is your responsibility to inform your parents regarding illness or injury.

**2. THIS FORM MUST BE COMPLETED IN ITS ENTIRETY** and returned to the Student Health Center by JUNE 30 for students enrolling in the fall semester, and by DECEMBER 30 for students enrolling in the spring semester. The Entrance Physical Exam should be completed prior to your arrival in Troy and must have been done in the past 12 months. If not completed, you will be referred to a local service at your expense. Students who do not submit their completed health form by the first day of class will have a medical hold placed on their account which will result in the inability to register for classes.

**3. You must complete pages 1 and 2 and sign the bottom of page 1.** If you are under the age of 18 upon your arrival in Troy, your parent(s) must sign at the bottom of page 1.

**4. Your Health Care Provider (MD, DO, RPA, RNP) must review the data on page 2 and complete pages 3 and 4.** He/she must sign pages 2, 3, and 4.

**5. FULL INSURANCE INFORMATION** is required for coordination of benefits. (Attach a copy of your insurance ID card.) Every student is required to have health insurance. A Health Insurance Fee will automatically appear on your tuition bill. If you already have health insurance through a family or other plan, and it covers *routine* and *non-emergency* care in the Troy area, you may elect to waive the PPO coverage and Health Insurance Fee. A Health Insurance Enrollment/Waiver form will be enclosed with the Fall tuition bill (Spring bills for students admitted or readmitted for the Spring semester). Those choosing to waive the insurance must renew their waiver each year.

**Completion of this section does not constitute waiving the insurance.**

I have coverage to age \_\_\_\_\_  I have no coverage.

Name of insurance company \_\_\_\_\_

Address of insurance company \_\_\_\_\_

Policy or identification number \_\_\_\_\_

Subscriber's name \_\_\_\_\_ Prescription coverage: Yes \_\_\_\_\_ No \_\_\_\_\_

**IF YOU ARE UNDER 18 years of age,** the following release must be signed by your parent(s) or guardian.

I/We give permission for our son/daughter to be treated by the Student Health Center and/or Counseling Center. I/We also authorize urgent or emergency treatment at the Samaritan Hospital. Financial coverage for medical care is subject to Rensselaer's student plan limitations.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**IF YOU ARE OVER 18 years of age,** please read and sign the following release.

In the event of serious physical or mental illness, I hereby consent to the notification of the person listed hereon as next of kin.

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

**For Office Use Only:**

Reviewed by \_\_\_\_\_ Date cleared \_\_\_\_\_ Date returned \_\_\_\_\_ Entered into PyraMed \_\_\_\_\_

# Medical History

Are you currently taking any medication, including inhalers?  Yes  No Please list \_\_\_\_\_

Are you taking any vitamin or herbal supplements?  Yes  No Please list \_\_\_\_\_

Do you have any allergies to medicines or environmental agents?  Yes  No

Please list \_\_\_\_\_

Alcohol Use  Yes  No Amount per week \_\_\_\_\_

Tobacco Use  Yes  No Amount per week \_\_\_\_\_

## FAMILY HISTORY

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

	Have any of your relatives ever had the following?		Relationship
	Yes	No	
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease/Sudden Death before age 55			
Arthritis			
Stomach or Intestinal Disease			
High Blood Pressure			
High Cholesterol			

## Personal History

**PLEASE ANSWER ALL QUESTIONS.** Comment on all positive answers, including dates, in the space below or on additional sheet.

HAVE YOU HAD?	Yes	No		Yes	No		Yes	No		Yes	No
Scarlet Fever			Worry or Nervousness			Surgery, Disease, or Injury of Bones or Joints			Seizure		
Chicken Pox			Recurrent Headaches				Heat Cramps			Venereal Disease	
Malaria			Recurrent Colds			Back Problems				Frequent Urination	
Gum or Tooth Trouble			Head Injury/Concussion			Tumor, Cancer, Cyst			Infectious Mononucleosis		
Sinusitis			Asthma/Wheezing			Jaundice			Thyroid Problems		
Eye, Ear, Nose, Throat Trouble			Tuberculosis			Stomach, Intestinal, Gallbladder or Stone Trouble			Sickle Cell Disease		
Surgery			Shortness of Breath				Rupture, Hernia			Anemia	
	Appendectomy		Pain/Pressure in Chest			Recent Gain or Loss of Weight			Lyme Disease		
	Tonsillectomy		Chronic Cough			Eating Disorder			<b>FEMALES ONLY</b>		
	Hernia Repair		Palpitations (Heart)				Irregular Periods/Lack of Periods				
Other		High or Low Blood Pressure			Dizziness, Fainting, Weakness, Paralysis			Severe Cramps			
Insomnia			Heart Disease/Murmur					Excessive Flow			
Anxiety/Depression			Diabetes								
Kidney Disease			Liver Disease/Hepatitis								

- Yes \_\_\_ No \_\_\_ **A.** Has your physical activity been restricted during the past five years? (Give reason, duration, and date)
- Yes \_\_\_ No \_\_\_ **B.** Have you had difficulty with school or teachers? (Give details)
- Yes \_\_\_ No \_\_\_ **C.** Have you had any illness or injury or been hospitalized other than already noted? (Give details)
- Yes \_\_\_ No \_\_\_ **D.** Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years (Give details)
- Yes \_\_\_ No \_\_\_ **E.** Have you been rejected/discharged from military service because of physical, emotional, or other reasons?  
(If so, give reasons)
- Yes \_\_\_ No \_\_\_ **F.** Have you consulted or been treated by a psychiatrist or psychologist? (Give details)
- Yes \_\_\_ No \_\_\_ **G.** Are you missing one of any paired organs (i.e., kidney, testicles)? (Give details)
- Yes \_\_\_ No \_\_\_ **H.** Have you had back problems severe enough to cause you to stop regular activities for more than a day?  
(Give reason, duration, and date)

## Remarks or Additional Information (Use additional sheet if necessary)

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# The Student Health Center

**To the Examining Practitioner:** Please review the student's history (page 2) and complete the physical examination and Student Immunization Record (pages 3 and 4). The information supplied will not affect his or her status; it will be used only as a background for providing health care, if this is necessary. This information is strictly for the use of the Student Health Center and will not be released without student consent.

<b>Family Name (Print)</b> _____		<b>First Name</b> _____	<b>Middle</b> _____
<b>BP</b> _____ / _____	<b>Height</b> _____ inches		<b>Weight</b> _____ lbs.
<b>Corrected Vision</b>	<b>Right 20/</b> _____	<b>Left 20/</b> _____	<b>Uncorrected Vision</b>
			<b>Right 20/</b> _____
			<b>Left 20/</b> _____

**RECOMMENDED LABORATORY DATA**

<b>Urinalysis:</b>  <b>Glucose</b> _____  <b>Protein</b> _____  <b>Micro</b> _____	<b>Blood:</b>  <b>Hemoglobin/Hematocrit</b> _____  <b>Cholesterol</b> _____
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**Physical Exam** Describe any abnormalities fully. Use additional sheet if needed.

	Normal	Abnormal
<b>1. Head, Eyes, Ears, Nose, or Throat</b>		
<b>2. Lymphatic</b>		
<b>3. Lungs</b>		
<b>4. Heart</b>		
<b>5. Abdomen</b>		
<b>6. Hernia</b>		
<b>7. Genitourinary/Testicles</b>		
<b>8. Musculoskeletal</b>		
<b>9. Neuropsychiatric</b>		
<b>10. Skin</b>		
<b>11. Rectal (if indicated)</b>		
<b>12. Pelvic (if indicated)</b>		
<b>13. Pap Smear (if indicated)</b>		

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

Is there any evidence of a heart murmur?     **Yes**     **No**

If yes, has the murmur been evaluated by Echo?     **Yes**     **No**

Has the murmur been determined by workup to be benign and not interfere with activity?     **Yes**     **No or not sure** (Please attach a copy of the cardiologist report or Echo)

Has this patient had a history of serious head injury/concussion?     **Yes** (Please describe)     **No**

Do you have any recommendations regarding the care of this student?     **Yes**     **No**

Does the patient use an inhaler prior to exercise?     **Yes**     **No**

Is this patient medically able to participate in NON-CONTACT sports?     **Yes**     **No**

Is this patient medically able to participate in CONTACT sports?     **Yes**     **No**

<b>Men's Contact Sports</b>			<b>Women's Contact Sports</b>		
<input type="checkbox"/> <b>Football</b>	<input type="checkbox"/> <b>Basketball</b>	<input type="checkbox"/> <b>Soccer</b>	<input type="checkbox"/> <b>Basketball</b>	<input type="checkbox"/> <b>Soccer</b>	<input type="checkbox"/> <b>Field Hockey</b>
<input type="checkbox"/> <b>Wrestling</b>	<input type="checkbox"/> <b>Lacrosse</b>	<input type="checkbox"/> <b>Hockey</b>	<input type="checkbox"/> <b>Lacrosse</b>	<input type="checkbox"/> <b>Hockey</b>	

Are there any special braces or pads to be worn for sports?     **Yes**     **No**

Please include any comments relevant to this student's medical care or limitations.

Date of Physical \_\_\_\_\_ Practitioner's signature \_\_\_\_\_

Family Name

First Name

Social Security #

Date of Birth

Student Immunization Record
PROOF OF IMMUNITY IS REQUIRED PRIOR TO REGISTRATION

This form must be completed in its entirety, complying with the guidelines specified exactly, for each disease. Failure to comply with the requirements will cause the form to be returned to you for completion. Please ensure that your physician completes the form as written. These requirements are in compliance with NYS Health Department immunization laws.

A. MEASLES (RUBEOLA) (SARAMPIÓN) (麻疹) (홍역) — NYS Health Department of Law — (REQUIRED)

- Born before 1957 and therefore considered immune
OR
Immune titer Date Result (attach lab report)
OR 2 shots required
Measles #1 MMR #1 Date after 12 months and after 1/1/68
Measles #2 MMR #2 Date

B. MUMPS (infectious parotitis) (PAPERAS) (流行性腮腺炎) (유행성 이하선염) — NYS Health Department of Law — (REQUIRED)

- Born before 1957 and therefore considered immune
OR
Immune titer Date Result (attach lab report)
OR
Mumps (if no MMR) Date after 12 months and after 1/1/68

C. RUBELLA (RUBÈOLA) (風疹) (풍진) — NYS Health Department of Law — (REQUIRED)

- Born before 1957 and therefore considered immune
OR
Immune titer Date Result (attach lab report)
OR
Rubella (if no MMR) Date after 12 months and after 1/1/68

D. TETANUS (TETANOS) (破傷風) (파상풍) — (REQUIRED)

- Primary series completed Yes No
Tetanus Booster within the past 10 years DT Date OR DTaP Date

E. TUBERCULOSIS SCREENING — (REQUIRED)

- Must be performed in the United States within the past 12 months. Required regardless of prior BCG inoculation.
PPD (Mantoux only) Date placed Date read Result Neg Pos mm induration (horizontal diameter)
If PPD is positive, chest X-ray is required, attach report: X-ray result Normal Abnormal
Preventative medical therapy received (if applicable) Date Duration months
Drug

F. MENINGITIS — (REQUIRED)

- Menactra Date OR Menomune Date

G. HEPATITIS B IMMUNIZATION — (VERY STRONGLY RECOMMENDED)

- First Dose date Second Dose date Third Dose date

H. HEPATITIS A IMMUNIZATION

- First Dose date Second Dose date

I. VARICELLA (Chicken Pox) VACCINATION/DISEASE

- Date of Disease Immune Titer Date Result
Vaccine First Dose date Second Dose date

J. GARDISIL (HPV)

- First Dose date Second Dose date Third Dose date

Date

PRACTITIONER'S Signature

Print PRACTITIONER'S Name

PRACTITIONER'S Address

PRACTITIONER'S Phone Number ( )

(Stamp may be used, but must be accompanied by signature and date)



Rensselaer

Return all information to:
Student Health Center
3200 Academy Hall
Rensselaer Polytechnic Institute
Troy, New York 12180-3590