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 Student Health Services and may not be released to anyone without your written consent.

Student Health Service
P.O. Box 2000, Cortland, NY 13045
p: 607-753-4811 f: 607-753-2486
w: cortland.edu/shs

Please indicate your date of entrance: 20______ ❐ Fall ❐ Spring ❐ Summer

Have you previously attended SUNY Cortland? ❐ Yes ❐ No If yes, when? ______

Entering as: ❐ Full time ❐ Part time

❐ Freshman/Undergraduate ❐ Transfer/Undergraduate ❐ Graduate

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

PLEASE PRINT IN BLACK INK

STUDENT ID/C #______________________

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) ______________

*Please bring a copy of your insurance card to campus with you.

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
Allergy:			
Penicillin	❐	❐	❐
Sulfonamides	❐	❐	❐
Serum	❐	❐	❐
Other __________	❐	❐	❐
Food (which) ______	❐	❐	❐
Chest Pain/Pressure	❐	❐	❐
Communicable Diseases:			
Chicken Pox	❐	❐	❐
Measles (rubeola)	❐	❐	❐
Mumps	❐	❐	❐
Rubella (German measles)	❐	❐	❐
Malaria	❐	❐	❐
Scarlet Fever	❐	❐	❐
Tuberculosis	❐	❐	❐
Dental Problems	❐	❐	❐
Diabetes	❐	❐	❐

Have you had:	Yes	No	Don't Know
Diarrhea (recurrent)	❐	❐	❐
Disease or Injury of Joints, Back	❐	❐	❐
Dizziness, Fainting	❐	❐	❐
Emotional Problems:			
Anxiety (frequent)	❐	❐	❐
Depression (frequent)	❐	❐	❐
Insomnia	❐	❐	❐
Eye Problems	❐	❐	❐
Gallbladder/Gallstone Trouble	❐	❐	❐
Hay Fever	❐	❐	❐
Head Injury with Unconsciousness	❐	❐	❐
Headaches (frequent)	❐	❐	❐
Heart Disease or Rheumatic Fever	❐	❐	❐
Hernia, Rupture	❐	❐	❐

Have you had:	Yes	No	Don't Know
High Blood Pressure	❐	❐	❐
Jaundice	❐	❐	❐
Mononucleosis	❐	❐	❐
Respiratory Problems:			
Asthma	❐	❐	❐
Cough (chronic)	❐	❐	❐
Ear, Nose, Throat Trouble	❐	❐	❐
Sinusitis	❐	❐	❐
Seizure Disorder	❐	❐	❐
Sexually Transmitted Disease	❐	❐	❐
Shortness of Breath	❐	❐	❐
Stomach or Intestinal Trouble	❐	❐	❐

Have you had:	Yes	No	Don't Know
Surgery __________	❐	❐	❐
Thyroid Problems	❐	❐	❐
Tumor, Cancer, Cyst	❐	❐	❐
Urinary Tract Problems:			
Albumin/Sugar	❐	❐	❐
Frequent Urination	❐	❐	❐
Other	❐	❐	❐
Weakness, Paralysis	❐	❐	❐
Weight Gain or Loss (recent)	❐	❐	❐
Females Only:			
Excessive Flow	❐	❐	❐
Irregular Flow	❐	❐	❐
Severe Cramps	❐	❐	❐

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

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

____

____

____

____

____

X ____

Student's signature Date

PLEASE PRINT IN BLACK INK

STUDENT ID/C #________________

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 or Menactra) 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 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. This section is REQUIRED for intercollegiate athletes and international students.

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 this 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______________________

____

____

REQUIRED FOR INTERCOLLEGIATE ATHLETES:

This student is able to participate in all physical activity including intercollegiate athletics Yes____ No ____

____

Examiner's (MD/NP/PA) signature

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
				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	#1 #2				
	Mumps (1 dose of live vaccine on or after first birthday) and					
	Rubella (1 dose of live vaccine on or after first birthday)					History of disease not acceptable
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 ____________

PART D: TUBERCULOSIS RISK ASSESSMENT REQUIRED - SEE TUBERCULOSIS SCREENING FORM