

New York Medical College

HEALTH SERVICES

HISTORY and PHYSICAL



HEALTH HISTORY

SS# _____

Name _____ Date of Birth _____ Age _____ Sex _____

Address _____

City _____ State _____ Zip _____

Religion _____ Marital Status _____ Telephone # _____

Place of Birth _____ U.S. Citizen — yes _____ no _____

If no, how long have you been in the U.S.A. _____

Department _____ Title _____ Start date _____

Father's Name _____ Place of Birth _____

Mother's Maiden Name _____ Place of Birth _____

Family Doctor's Name _____

Address _____ Phone # _____

Health Insurance _____ Policy or ID # _____

Other Ins. Information _____

Emergency Contact _____ Relationship _____

Home phone # _____ Business phone # _____

MILITARY SERVICE

Have you served in the Armed Forces? _____ Date of Discharge _____

Any service related disabilities? _____

FOR WOMEN ONLY:

Do you menstruate? _____ Date of Last menstrual period _____ / _____ / _____

Last routine gyn/pap smear _____ / _____ / _____

Do you examine your breasts? _____ If over 40, have you ever had a mammogram? _____

If yes, when? _____ / _____ / _____

HEALTH HISTORY CONTINUED

FAMILY HISTORY

Using Key, indicate if your immediate family has had any of the following:

KEY: **M**—Mother
F—Father
S—Sibling

A—Aunt
U—Uncle
GM—Grandmother
GF—Grandfather

Yes	NO		Key:	Comments:
		Cancer		
		Diabetes		
		Emphysema		
		Heart Disease		
		High Blood Pressure		

PERSONAL MEDICAL HISTORY:

Please indicate if you have had any of the following: If YES, please comment below.

Yes	No		Yes	No	
		Allergies			High Blood Pressure
		Asthma			Jaundice
		Cancer			Kidney Disease
		Diabetes			Low back pain
		Epilepsy			Tuberculosis
		Heart Disease			On an medications presently
		Hospitalization(s)			Other
		Previous Surgery			Drug Allergies

Date of last tuberculin test _____/_____/_____

Last Tetanus booster _____/_____/_____

Do you smoke? _____

Comments: _____

Applicant's Signature _____

Date _____

New York Medical College Immunization Record

NAME: _____ SS#: _____

DOB: _____ / _____ / _____ CLASS YR: _____

PLEASE READ CAREFULLY! EVERYTHING APPLIES!

New York State law mandates all students born on or after January 1, 1957 must show protection against Measles, Mumps and Rubella. THIS FORM REQUIRES A PHYSICIAN'S SIGNATURE.

MMR Vaccine

MMR: Measles, Mumps, and Rubella. MMR vaccine is required to provide increased protection against all three vaccine-preventable diseases. If MMR vaccine is used please give dates:

1) _____ / _____ / _____ (2) _____ / _____ / _____
Month Day Year Month Day Year

Measles (Rubeola) Immunity

The first Measles vaccine must be administered after the first birthday and the second measles vaccine must be administered on or after 15 months of age.

1. TWO dates of Measles immunization: (1) _____ / _____ / _____ and 2) _____ / _____ / _____
 2. Date of Measles titer: _____ / _____ / _____ Result: _____ (**ENCLOSE COPY OF LAB REPORT**)
-

Mumps Immunity

The Mumps vaccine must be administered after the first birthday.

1. Date of Mumps immunization: _____ / _____ / _____
 2. Date of Mumps titer: _____ / _____ / _____ Result: _____ (**ENCLOSE COPY OF LAB REPORT**)
-

Rubella (German Measles) Immunity

The Rubella vaccine must be administered after the first birthday.

1. Date of Rubella immunization: _____ / _____ / _____
2. Date of Rubella titer: _____ / _____ / _____ Result: _____ (**ENCLOSE COPY OF LAB REPORT**)

Varicella (Chicken Pox)

DOCUMENTATION OF VARICELLA DISEASE IS NOT ACCEPTABLE. (TITER IS MANDATORY FOR CLINICAL ROTATIONS). If Varicella IGG is negative, documentation of (two) 2 doses of the Varivax vaccine given four (4) weeks apart is required prior to matriculation.

Varicella IGG Titer Date: ___ / ___ / ___ Results: _____ (**ENCLOSE COPY OF LAB REPORT**)

Varivax #1 Date: ___ / ___ / ___ Varivax #2 Date: ___ / ___ / ___

Hepatitis B

Hepatitis B Vaccination Series dates

(1) ___ / ___ / ___ (2) ___ / ___ / ___ (3) ___ / ___ / ___

Hepatitis B Surface Antibody

(HBsAB Titer) Date: ___ / ___ / ___ Results: _____ (**ENCLOSE COPY OF LAB REPORT**)

Td Tetanus/diphtheria

Date of last (Td) Booster: ___ / ___ / ___ (Must be given within the past 10 years)

Polio

Date of last oral Polio booster: ___ / ___ / ___

PPD tuberculosis skin test (Mantoux)
(PPD must be within one year)

PPD skin test required even with BCG vaccination. Tine test in not acceptable.

Date PPD planted: ___ / ___ / ___ Date read: ___ / ___ / ___ Results _____ (in mm)

If skin test is equal to or greater than 10 mm, a Chest x-ray (report only - no films) is required within one year.

IF PPD POSITIVE:

Submit documentation of date and measurement of induration of positive PPD result read by a private medical doctor.

Date of Positive PPD: ___ / ___ / ___ Results of induration _____ (in mm)

Date of chest x-ray (must be within one year): ___ / ___ / ___ Result:

A copy of the chest x-ray report must be enclosed.

Was patient treated with INH? Yes No

What was the date and duration of INH treatment: _____

Physician's Name (Please Print)

Signature

Date

Address: _____
(Print or Stamp)

Phone number: _____

URGENT NOTICE- PLEASE READ AND RESPOND

Meningococcal

To be completed and signed by student:

- Quadrivalent polysaccharide vaccine (Menomune)..... Date ____/____/____
- I have read or have had explained to me, the information regarding meningococcal meningitis disease. I will obtain immunization against meningococcal meningitis within 30 days of the beginning of the next semester.
- I have 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 will **not** obtain immunization against meningococcal meningitis disease.

For more information visit CDC’s meningococcal disease website at:

www.cdc.gov/ncidod/dbmd/diseaseinfo/meningococcal_g.htm

Signed _____ Date _____

Release of Immunization Records

I hereby give my authorization to Health Services to release my medical records to any or all of my future rotations at various hospitals during my education here at NYMC.

I understand that in order to work in these medical institutions, it is mandated by New York State Law that each hospital has on file a copy of my medical records in order to show proof of proper immunizations.

Print Name: _____

SS#: _____ - _____ - _____ Class Yr: _____

Signature: _____ Date: _____

This form must be completed in its entirety and returned to:

***New York Medical College
Health Services
Basic Science Building
Valhalla, New York 10595***

MSW: IR
JA: Revised May 2006