New York Medical College
A MEMBER OF THE TOURO COLLEGE AND UNIVERSITY SYSTEM

HEALTH SERVICES

HISTORY and PHYSICAL
GENERAL INFORMATION

Last Name _____________________________________First Name _____________________________________

Date of Birth ____________________ Age __________ Sex (M,F) __________ Marital Status __________

Local Address________________________________ City______________________ State________ Zip____

E-Mail address________________________________ Cell #____________________ Home#_______________

Religion_______________ Place of Birth (City, Country)______________________ U.S. Citizen: (Y,N) ____

Have you lived outside the US during the last five years? If yes, where? ______________________________

Father’s Name__________________________________________ Place of Birth______________________

Mother’s Maiden Name___________________________________ Place of Birth______________________

Family Doctor’s Name_____________________________________

Address _____________________________________________ Phone ______________________________

Health Insurance__________________________________ Policy/ID #_____________________________

Emergency Contact ___________________________________________ Relationship___________________

Home phone #___________________ Cell phone #_______________ Work phone# ___________________

Employees Only

Start Date:________________________________   Title:  _____________________________________

Department:______________________Location:__________________Office #:____________________

Tuberculosis Screen

Have you had a tuberculin skin test? Yes/No (circle)

Date of last tuberculin skin test (PPD): _____/_____/_____ Results: Negative /Positive (circle) ____mm

For persons with previous positive tuberculin skin test:

Provide date of most recent x-ray ________ (provide report)

Were you treated for latent tuberculosis: If yes, date you started treatment: ___________

Medication taken: __________ Number of months treated: __________

Have you had any of the following symptoms for more than one week; If yes, circle the symptom(s): Cough, Fevers, Night sweats, Excessive fatigue, Unexplained weight loss, Coughing up blood.
FAMILY HISTORY

Using the 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

<table>
<thead>
<tr>
<th>YES: Key</th>
<th>NO</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PERSONAL MEDICAL HISTORY

Please indicate if you have or had any of the conditions below. If YES, please specify if condition is still active and under treatment. **Circle Yes/No**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes/No</th>
<th>Condition</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td>Yes/No</td>
<td>Hearing Loss or problems</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Asthma or Lung disease</td>
<td>Yes/No</td>
<td>Headaches</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Back problem</td>
<td>Yes/No</td>
<td>Heart Disease</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Bone or Joint disorder</td>
<td>Yes/No</td>
<td>High Blood Pressure</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Cancer</td>
<td>Yes/No</td>
<td>Immune-compromising condition</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Yes/No</td>
<td>Jaundice/Hepatitis</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Drug Allergies (please specify)</td>
<td>Yes/No</td>
<td>Kidney / Bladder disorder</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Ears, Nose or Throat disorder</td>
<td>Yes/No</td>
<td>Skin disorder</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Epilepsy, seizures</td>
<td>Yes/No</td>
<td>Tuberculosis</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Gastrointestinal disorder</td>
<td>Yes/No</td>
<td>Vision Problems</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

**FOR WOMEN ONLY:** Date of last gynecological exam:_______ last breast exam:______ last menses:

Current Medications

__________________________________________________________________________

Have you ever smoked? ______________ pack/day ___________ number of years ___________

Hospitalizations/Surgeries

Comments______________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Applicant Signature:______________________________________ Date:_______________________

Your signature above certifies that the information is true to the best of your knowledge.
If finding is normal circle N
If abnormal so indicate and explain

Name: ________________________________
Date of Exam: ___________________________

**PHYSICAL EXAMINATION**

Height ______ Weight______ Temperature _______ Pulse______ Blood Pressure____________________

General Condition: ________________________________ Emotional Status: Apparently Normal

**ENT:**
- Ears  N ___________________________
- Eyes  N ___________________________
- Pupils  N ___________________________
- Nose  N ___________________________
- Throat  N ___________________________
- Tonsils  N Absent_____________________
- Neck  N ___________________________
- Thyroid  No thyromegaly or palpable nodules ___

**CHEST:**
- Lungs  N ___________________________
- Breasts  N ___________________________

**HEART:**
- Size  N ___________________________
- Rhythm RSR ___________________________
- Murmurs  None ___________________________

**ABDOMEN:**
- Inspection  N ___________________________
- Palpation  N ___________________________
- Organs  No HSM ___________________________
- Tenderness  N ___________________________
- Masses  None ___________________________
- Scars  None ___________________________

**EXTREMITIES:**
- Edema  None ___________________________
- Varices  None ___________________________
- Arches  N ___________________________
- Peripheral vascular  N ___________________________

**NEUROLOGICAL:**
- Deep tendon reflexes  N ___________________________

**ORTHOPEDIC:**
- Bones & Joints  N ___________________________

**LYMPHATICS:**
- Spleen  N ___________________________
- Lymph nodes  N ___________________________

**EXTREMITIES:**
- Edema  None ___________________________
- Varices  None ___________________________
- Arches  N ___________________________
- Peripheral vascular  N ___________________________

**ENT:**
- Ears  N ___________________________
- Eyes  N ___________________________
- Pupils  N ___________________________
- Nose  N ___________________________
- Throat  N ___________________________
- Tonsils  N Absent_____________________
- Neck  N ___________________________
- Thyroid  No thyromegaly or palpable nodules ___

**CHEST:**
- Lungs  N ___________________________
- Breasts  N ___________________________

**HEART:**
- Size  N ___________________________
- Rhythm RSR ___________________________
- Murmurs  None ___________________________

**ABDOMEN:**
- Inspection  N ___________________________
- Palpation  N ___________________________
- Organs  No HSM ___________________________
- Tenderness  N ___________________________
- Masses  None ___________________________
- Scars  None ___________________________

Summary:___________________________________
___________________________________________
___________________________________________
___________________________________________
___________________________________________
___________________________________________

Provider’s Signature:__________________________

Revised:4/27/2015 ps
Student Immunization Record

Name:___________________________________________   DOB: ______________________

Program:_________________________________________ Class year: __________________

PLEASE READ CAREFULLY!
THIS FORM REQUIRES A PHYSICIAN’S SIGNATURE.

New York State law mandates all students to show protection against Measles, Mumps and Rubella. Date of receipt of vaccinations requires a month, day and year.

**Measles, Mumps, Rubella (MMR): Vaccination AND Titors Required**
Anyone born after 1957 must be vaccinated against Measles, Mumps and Rubella. The first MMR vaccine must be administered after the first birthday and the second MMR vaccine must be administered on or after 15 months of age.

*Must show proof of immunizations and titors:*

1. TWO dates of MMR immunization: (1) _____________ and (2) _____________

   2. Measles titer date: ________ Result: ________ *(ENCLOSE COPY OF LAB REPORT)*
   Mumps titer date: ________ Result: ________ *(ENCLOSE COPY OF LAB REPORT)*
   Rubella titer date: ________ Result: ________ *(ENCLOSE COPY OF LAB REPORT)*

**Varicella (Chicken Pox): Vaccination OR Titors Required**
(If both are available, vaccination record and titer, submit both). A health care providers documentation of Varicella disease is NOT acceptable as proof of Varicella. A titer indicating immunity or evidence of vaccination is mandatory for clinical rotations. If Varicella IgG is negative, documentation of 2 doses of the Varicella vaccine given at least 4 weeks apart is required.

Varicella IgG titer date: ____________ Result:__________ *(ENCLOSE COPY OF LAB REPORT)*

Varicella vaccination #1 Date: ________________ #2 Date: ________________

Healthcare Provider’s Signature:________________________________________________
Student Name:_______________________

**Hepatitis B: Vaccination AND Quantitative HBV Surface Antibody Required:** Hepatitis B Vaccination Series dates

(1) __________   (2) __________   (3) __________

Hepatitis B Surface Antibody  **(Must be QUANTITATIVE)**

(HBsAB Titer) Date:__________ Results: ________ *(ENCLOSE COPY OF LAB REPORT)*

____________________________________________________________________________

**Tetanus, Diphtheria, Pertussis: Booster within 10 years Required**

Date of last (Td) Booster: __________ *(Must be given within the past 10 years)*  OR

Date of Tdap: ______________ (preferred)

____________________________________________________________________________

**Polio: Date of Last Booster:**

Date of last Polio booster (oral or inactivated): ______________

____________________________________________________________________________

**Meningococcal:**

To be completed and signed by student: (check one box and sign)

□ I had meningococcal meningitis immunization…..Date of vaccine:_____________

□ 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: [http://www.cdc.gov/ meningococcal/about/index.html](http://www.cdc.gov/ meningococcal/about/index.html)

Signed:_____________________________________ (student)  Date:_____________________

Healthcare Provider’s Signature:_________________________________________________
Student Name:_______________________

**Tuberculosis Screen: PPD skin test (Mantoux) or Quantiferon Gold Required**
(The test must be within one year of matriculation)

**Tuberculosis Screen required even with history of BCG vaccination.**

Date PPD planted: __________  Date read: ___________  Results: ___________  (in mm)

OR

Date of Quantiferon Gold Test: ___________________Results:__________________________

*(ENCLOSE COPY OF LAB REPORT)*

For persons with a history of positive PPD (equal to or greater than 10 mm induration) or a positive Quantiferon Gold Test: a Chest x-ray (report only - no films) is required within one year of matriculation.

Date of chest x-ray: ______________ Result: _____________

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

Was patient treated with INH or other TB treatment?  □ Yes  □ No

What was the date, type and duration of treatment: ____________________________________

_______________________________________________________________________________

_________    ____________    __________
Healthcare Provider’s Name                                    Signature                                    Date
(Please Print)  

Address: ________________________________________________________________________

Phone number: ____________________________________________________________________

(Print or Stamp)
Release of Records

I hereby give my authorization to the New York Medical College Health Services Office 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: ____________________________________________________________

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