NYMC/TCDM Health Services- ***Medical History and Physical Exam***

Last Name/ First Name: _____ **Touro ID:** _____

Part I: Student section: ONLY return form after BOTH student & physician section are completed.

General Information				
Date of Birth ___/___/_____	Sex (M/F)	Email		
Local Physical Address		City	State	Zip
Cell#	Home#			
Physician's Name				
Physician's Phone#	City	State		
Name of Health Insurance Company				
Policy ID#	Policy Group#	Prescription #		
Name of Health Insurance Policy Holder ☐ Check here if you are the Policy Holder	Policy Holder Date of Birth:	Policy Holder Relationship to Student		
Name of Emergency Contact		Relationship		
Home phone #	Cell phone #	Work phone #		

Current and Past Medical History		
Have you had surgery?	☐No	☐Yes – Specify procedure(s) and year
Have you been hospitalized?	☐No	☐Yes – Specify reason(s) for hospitalization and year
Do you have **past** medical condition(s)?	☐None	☐Yes; Please specify past conditions
Do you have **current** medical condition(s)?	☐None	☐ Yes; Please specify current conditions

NYMC Health Services helps connect students in need of ongoing care. Please call our office (914) 594-4234 for assistance.

NYMC/TCDM Health Services- *Medical History and Physical Exam*

Last Name/ First Name: _____ **Touro ID:** _____

Mental Health & Wellness: Data below are reviewed by Mental Health & Wellness. NYMC offers No-Cost Mental Health & Wellness Services with 24/7 Support**.** Questions? Call or visit us at (914) 594-2538 NYMC Student Mental Health & Wellness.

Have you previously experienced, or do you **currently** have any **mental health condition(s)**?	☐No	☐Yes: specify below:

☐Anxiety ☐ADHD ☐Bipolar Disorder ☐Depression ☐Eating Disorder
☐Obsessive Compulsive Disorder ☐Substance Use/Abuse ☐Schizophrenia ☐Trauma
☐ Other (please specify)

If currently experiencing mental health conditions, are you currently followed by a practitioner? ☐Yes ☐No

Medications:		
Are you currently taking any medications?	☐No	☐Yes, please specify
Do you have allergies to medications, food other?	☐No	☐Yes, please specify allergy and reaction

Family History:
List any significant family history: List disease and relationship

Personal and Social History		
Have you lived outside the U.S. for more than one month?	☐No	☐Yes: Specify country, when and where you lived
Have you or do you smoke/ vape?	☐No	☐Yes: Specify amount and duration below
Do you feel that you are habitually using any drugs or alcohol?	☐No	☐Yes: Please specify below

Review of Systems: Please indicate by checking the appropriate box, or list the condition in the system; Specify if other	
General: ☐weight gain, ☐weight loss	GI: ☐constipation, ☐diarrhea, ☐rectal bleeding, ☐stomach pains, ☐hepatitis, ☐other
Skin: ☐rashes, ☐other	GU: ☐blood in urine, ☐testicular lumps, ☐other
HEENT: ☐head injury, ☐hearing disorder	GYN: ☐abnormal menses, ☐other
Neck: ☐swollen glands, ☐thyroid disorder	Blood or Immune disorder - ☐If yes, please specify:
Lungs: ☐wheezing, ☐infections, ☐other	Neurologic: ☐headaches, ☐seizures, ☐vision disorder
Cardiac: ☐high/low blood pressure, ☐cardiac disorder	Skeletal: ☐Joint pain, ☐back problems, ☐other:
Endocrine: ☐diabetes, ☐thyroid disorder, ☐other	Psychiatric: ☐anxiety, ☐sleep issues, ☐mood swings, ☐depression

Last Name/ First Name: _____ **Touro ID:** _____

Part II: Physician Section:
ONLY return form after BOTH student & physician section are completed.

Student medical history, medications and review of systems reviewed check here ☐

TUBERCULOSIS (TB) RISK ASSESSMENT as per NYSDOH guidelines			
1. Has the patient ever had a positive tuberculin skin test (TST) or IGRA (QuantiFERON) or evidence of TB?		☐ No	☐ Yes: Specify below
Test Date:	For TST, provide mm: For IGRA, Lab report of prior test is provided: Check here: ☐		
CXR after positive TST or IGRA:	CXR Date:	CXR report attached to this form: Check here: ☐	
2. Has the patient ever been treated for latent TB or active TB?		☐ No	☐ Yes Specify
Medications	Dates Medication Received		

3. **TB Symptom Survey for Persons with History of Latent or Active TB:** Check here if *not* applicable ☐

Specify details below if the patient has any of the following symptoms: Persistent cough > 2 weeks; Cough producing phlegm or blood; Enlarged lymph nodes in the neck or upper chest; Unexplained fever or night sweats or chills for longer than 2 weeks; Unexplained weight loss of > = 5 lbs.

TB Screening for Students with NO History of Latent/Active TB
Can be done by IGRA (QuantiFERON) OR TST performed at the time of physical exam.

For TST performed at visit: Lot # _____ TST Lot # Expiration Date _____

Date TST placed __/__/____ TST Result (positive / negative) and mm: _____ _____ mm

Date TST read __/__/____ **If newly positive TST:** Date of CXR ordered ___/___/_____

Last Name/ First Name: _____ **Touro ID:** _____

Part II: Physician Section:
ONLY return form after BOTH student & physician section are completed.

PHYSICAL EXAMINATION					
Date of Exam	Height	Weight	Temp	Pulse	BP
General:			Lymphatic:		
Skin:			Abdomen:		
HEENT & Neck:			Extremities:		
Lungs:			Musculoskeletal:		
Heart:			Neurologic:		
Breasts/ Testicles:			Other Findings:		

HEALTH PROVIDER ASSESSMENT

Please check one after you have reviewed the student's medical information.

☐ The student has no medical limitation for ongoing health professional and clinical studies.

☐ The student has the following health condition(s) for which continuation of care is required. Please specify as to whether this poses a limitation or restriction for clinical activities.

Provider Name (Please print) _____ State and License# _____

Signature Date Phone Number