



**MONROE COMMUNITY COLLEGE**

**HEALTH SERVICES DEPARTMENT**

## **HEALTH HISTORY & PHYSICAL EXAM FORM**

### **Purpose:**

Completion of this packet is requested as part of the admissions process. The information you provide will be evaluated against the essential/technical standards that have been validated as essential for participation in the particular program for which you have applied.

### **Instructions:**

Please complete Part 1, sections 1 through 6 of this packet. Be sure you sign and date the forms where it's requested. **All entries made by you need to be in ink.**

There is also an insert sheet of questions that must be completed by students entering the Nursing, Radiologic Technology, Dental, Massage Therapy and EMS programs.

Your physician or health care provider needs to complete Part 2, the Physician/Health Care Provider Section, when you have your physical examination.

All of these forms must be completed and in compliance with requirements before review by Health Services Department nursing staff.

*Monroe Community College is a unit of the State University of New York. It is the policy of the University and College not to discriminate on the basis of age, sex, race, religion, national origin, color, disability or marital status in admission, employment, and treatment of students and employees in any educational activity administered by any of its units.*

**PART 1**

**TO BE COMPLETED**

**BY STUDENT**

*PART 1 – Complete section 1 through 6 and sign where requested.*

**SECTION 1 – STUDENT COMPLETE THIS SECTION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Student ID# \_\_\_\_\_ SS# \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

Tel. Number: ( ) \_\_\_\_\_ Cell Number: ( ) \_\_\_\_\_ Primary Care Physician Tel. Number: ( ) \_\_\_\_\_

If you are a student, indicate program (check one)  
 EMT     Nursing     Dental Hygiene     Radiologic Technology     Massage Therapy     Health Info. Tech

**SECTION 2 – STUDENT COMPLETE THIS SECTION**

IF THE ITEM LISTED BELOW HAS BEEN A <b>PROBLEM</b> IN THE PAST, OR IS CURRENTLY A PROBLEM, WRITE YES AND EXPLAIN.		
	YES	EXPLANATION
ALCOHOLISM		
ARTHRITIS		
ANEMIA		
SICKLE CELL DISEASE		
ASTHMA		
SHORTNESS OF BREATH		
WHEEZING		
CHRONIC COUGH		
SWOLLEN GLANDS		
CHRONIC SORE THROAT		
FREQUENT HOARSENESS		
TUBERCULOSIS		
EMPHYSEMA		
BLEEDING TENDENCY		
CANCER		
UNUSUAL BLEEDING		
CIRRHOsis		
HEPATITIS		
JAUNDICE		
KIDNEY PROBLEMS/DISEASE		
WEAK URINARY STREAM		
PAINFUL URINATION		
CLOUDY OR BLOODY URINE		
ULCER (STOMACH OR DUODENAL)		
VOMITING BLOOD		
COLITIS		
CHANGE IN BOWEL HABITS		
DIARRHEA		
BLACK OR BLOODY STOOLS		
CONSTIPATION		
DIFFICULTY SWALLOWING		
MENTAL ILLNESS		
DEPRESSION (MODERATE)		
UNUSUAL FEELING OF TENSION, ANXIETY, UNHAPPINESS		
DIFFICULTY SLEEPING		
EXTREME FATIGUE		
DIABETES MELLITUS		
HERNIA		

**SECTION 2 (Cont.) – STUDENT COMPLETE THIS SECTION**

IF THE ITEM LISTED BELOW HAS BEEN A <b>PROBLEM</b> IN THE PAST, OR IS CURRENTLY A PROBLEM, WRITE YES AND EXPLAIN.		
	YES	EXPLANATION
HEART DISEASE		
HEART MURMUR		
HIGH BLOOD PRESSURE		
IRREGULAR HEART BEAT		
PALPITATIONS		
CHEST PAIN		
SWOLLEN ANKLES		
RHEUMATIC FEVER		
STROKE		
THYROID PROBLEM		
FEVER (PROLONGED)		
EXCESSIVE WEIGHT LOSS/GAIN		
LOSS OF APPETITE OR EXCESSIVE HUNGER		
NAUSEA		
VOMITING		
BACK PAIN		
JOINT OR MUSCLE PAIN		
HEADACHE (FREQUENT OR SEVERE)		
LOSS OF CONSCIOUSNESS/FAINTING		
LOSS OF HEARING		
EPILEPSY OR SEIZURES		
WEAKNESS OR PARALYSIS		
NUMBNESS OR TINGLING		
DIZZINESS		
EYE PAIN		
BLURRING/LOSS OF VISION		
EXCESSIVE SWEATING OR HOT FLASHES		
SKIN RASH, BURNING OR ITCHING		
SKIN INFECTIONS		
SKIN SORE THAT DOESN'T HEAL		
MOLE THAT HAS CHANGED COLOR OR SIZE		
PAIN OR LUMP IN BREAST		
VAGINAL DISCHARGE		
PAIN OR SWELLING IN TESTICLES		
SORE OR DISCHARGE FROM PENIS		
DRUG ADDICTION		

I attest to the truthfulness of the above statements and that I am free from habituation or addiction to depressants, stimulants, narcotics and other behavior altering substances.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

**SECTION 3 – STUDENT COMPLETE THIS SECTION**

**FAMILY HISTORY:**

Are your parents, siblings, children still alive? If not, fill in below.

Family Member	Father	Mother	Sister/Brother	Children

**Check any health problems which your family members have had:**

- |                        |                          |                                    |                          |
|------------------------|--------------------------|------------------------------------|--------------------------|
| Bleeding tendency..... | <input type="checkbox"/> | Stroke.....                        | <input type="checkbox"/> |
| Heart Disease.....     | <input type="checkbox"/> | Kidney disease.....                | <input type="checkbox"/> |
| Cancer.....            | <input type="checkbox"/> | Tuberculosis (recent history)..... | <input type="checkbox"/> |
| Mental Illness.....    | <input type="checkbox"/> | High blood pressure.....           | <input type="checkbox"/> |
| Diabetes.....          | <input type="checkbox"/> |                                    |                          |

**SECTION 4 – STUDENT COMPLETE THIS SECTION**

**PERSONAL HISTORY (CONTINUED):**

Do you have any limitations of physical activities?

\_\_\_NO \_\_\_YES IF YES, EXPLAIN: \_\_\_\_\_

Do you have medication allergies or **severe** allergies to bee stings or other substances?

\_\_\_NO \_\_\_YES IF YES, EXPLAIN: \_\_\_\_\_

Do you take any medicines on a regular basis? If YES, list names of medicines, the doses and how often you take it.

\_\_\_NO \_\_\_YES IF YES, EXPLAIN: \_\_\_\_\_

Do you have any **current** problems (physical or emotional handicaps) that you would like Health Services to be aware of?

\_\_\_NO \_\_\_YES IF YES, EXPLAIN: \_\_\_\_\_

In the space below, please list all hospitalizations, surgeries, biopsies, fractures or other serious injury. Identify the problem and date if within the past five years.

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**SECTION 5 – STUDENT COMPLETE THIS SECTION**

**Medical Records Release Authorization**

I hereby authorize Monroe Community College Health Services to furnish a copy of my medical history and physical examination form upon request by affiliating clinical agencies as required by New York State law.

I understand that I have a right to receive a copy of this authorization upon request.

This authorization shall become effective immediately and shall remain in effect until I complete my course of studies in the \_\_\_\_\_ Program or until I am no longer employed as a faculty member in the \_\_\_\_\_ Department.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**SECTION 6 – STUDENT COMPLETE THIS SECTION**

**Student Checklist**

The Student Evaluation Checklist for your health Career Program is included. Please complete before signing below.  
\*\*\*\*\*Not required for Health Information Technology\*\*\*\*\*

I attest to the truthfulness of responses to sections 1 through 6.

\_\_\_\_\_  
STUDENT SIGNATURE

\_\_\_\_\_  
DATE

If you are under 18, this authorization must also be signed by a parent or guardian.

\_\_\_\_\_  
PARENT OR GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

**ATTENTION!**

- THE REMAINING PORTION OF THIS PACKET (PART II) IS TO BE COMPLETED BY YOUR PHYSICIAN/HEALTH CARE PROVIDER -

## **PART II**

**TO BE COMPLETED  
BY PHYSICIAN OR  
HEALTH CARE  
PROVIDER**

PART II – To be complete by Physician or Health Care Provider. Please review preceding pages with individual.

**SECTION 1 – TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROVIDER FOR ALL STUDENTS**

Please complete all boxes.

	DATE	NEG.	POS.
Mantoux P.P.D. skin test <b>(Required - within one year)</b> ; Intradermal P.P.D. is required (Tine test is not acceptable)*			
<b>*if P.P.D. is or has been positive, a chest x-ray within the past year is required</b> Chest x-ray <input type="checkbox"/> normal <input type="checkbox"/> abnormal			
<b>RUBELLA</b> immunity is REQUIRED for ALL STUDENTS in a medical program regardless of age. Date of Rubella Vaccine (Must be 1969 or later and on or after 1 <sup>st</sup> birthday)			
<b>OR positive</b> Rubella blood Titer test			
Tetanus Diphtheria Toxoid <b>(Required - within ten (10) years)</b>			

**HEPATITIS B INFORMATION:**

I understand that due to my occupational exposures to blood I may be at risk of acquiring Hepatitis B virus infection. I have read the informational materials sent to me by Monroe Community College.

I did receive Hepatitis B immunizations. (Please enter dates or check to decline)

Dose # 1 \_\_\_\_\_  
Dose # 2 \_\_\_\_\_  
Dose # 3 \_\_\_\_\_

**OR**

Decline the vaccine at this time.

I understand that by declining I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood and wish to be vaccinated with the Hepatitis B vaccine, I can receive this vaccine from my physician or from the health care agency that employs me.

Student Signature: \_\_\_\_\_ Date \_\_\_\_\_

**If this person was born January 1, 1957 or later they are required by New York State law to provide proof of immunity as follows:**

**MEASLES VACCINE**, 1968 or later and on or after first birthday. Two doses of live vaccine are required at least thirty (30) days apart.

Dose #1 \_\_\_\_\_ Dose #2 \_\_\_\_\_ **OR** MMR Dose 1 \_\_\_\_\_ Dose 2 \_\_\_\_\_  
(mo/day/yr) (mo/day/yr) (mo/day/year) (mo/day/year)

**OR** physician diagnosed disease \_\_\_\_\_  
(mo/day/year)

**OR positive** measles blood titer test - \_\_\_\_\_  
(mo/day/yr)

**MUMPS VACCINE**, 1969 or later and on or after first birthday. \_\_\_\_\_  
(mo/day/yr)

**OR** physician diagnosed disease \_\_\_\_\_  
(mo/day/year)

**OR positive** mumps blood titer test - \_\_\_\_\_  
(mo/day/yr)

**Meningitis Vaccine** I did receive the meningitis vaccine on \_\_\_\_\_  
(mo/day/year)

**OR**

I have received the information regarding meningitis and decline to receive the vaccine at this time. I understand that by declining I could be at risk of contracting meningitis.

Signature

Date

**SECTION 2 – TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROVIDER**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Uncorrected Vision: R \_\_\_/\_\_\_ L \_\_\_/\_\_\_

**OR**

Corrected Vision R \_\_\_/\_\_\_ L \_\_\_/\_\_\_

AREA EXAMINED	NORMAL	ABNORMAL	NOT EXAMINED	DESCRIBE ABNORMAL FINDINGS
<b>• HAND/SKIN</b>	<input type="checkbox"/>	<input type="checkbox"/>		
Hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skin/Color/Texture/Hydration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tattoos/Scars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>• HEAD/EYES</b>	<input type="checkbox"/>	<input type="checkbox"/>		
Lids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Conj/Sclera	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pupils/Equal/Light Reaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fundi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Extracular Movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>• EARS/NOSE/THROAT/MOUTH</b>	<input type="checkbox"/>	<input type="checkbox"/>		
Pinna/Canals/Tympanic Membrane	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nasal Septum/Mucosa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Teeth/Gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tongue/Palate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tonsils/Pharynx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>• NECK/NODES</b>	<input type="checkbox"/>	<input type="checkbox"/>		
Bruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Range of Motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Muscle Strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neck Nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Inguinal/Axillary Nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>• CHEST/LUNGS</b>	<input type="checkbox"/>	<input type="checkbox"/>		
Shape	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Percussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Auscultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Breast (Discharge/Masses)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>• CARDIOVASCULAR</b>	<input type="checkbox"/>	<input type="checkbox"/>		
Carotid Arteries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neck Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Apical Impulse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Murmurs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Size	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**SECTION 2 – CONTINUED**

AREA EXAMINED	NORMAL	ABNORMAL	NOT EXAMINED	DESCRIBE ABNORMAL FINDINGS
<b>• ABDOMEN</b>	<input type="checkbox"/>	<input type="checkbox"/>		
Scars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bowel Sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Organomegaly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Guarding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Masses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>• MUSCULOSKELETAL/EXTREMITIES</b>	<input type="checkbox"/>	<input type="checkbox"/>		
Extremities (Edema/Varicosity)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Joints/Amputations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Range of Motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pulses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>• MUSCULOSKELETAL/SPINE</b>	<input type="checkbox"/>	<input type="checkbox"/>		
Spinal Alignment/Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Range of Motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>• NERVOUS SYSTEM</b>	<input type="checkbox"/>	<input type="checkbox"/>		
Cranial Nerves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sensory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reflexes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>• GENITALIA/RECTAL</b>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>MALE:</b> Penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Scrotum/Testes (hernia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prostate/Rectum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>FEMALE:</b> Perineum/Vagina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cervix/Uterus/Adnexa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**SECTION 3 – PHYSICIAN OR HEALTH CARE PROVIDER, carefully read the following statement, and check the appropriate boxes.**

1. Are there musculoskeletal restrictions related to mobility, range of motion, lifting, or manual dexterity?  Yes  No If yes, please explain:

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2. Are there hearing restrictions which would impair the student from hearing audible alarms or engaging in telephone or oral communication with patients?  Yes  No If yes, please explain:

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3. Are there uncorrected sight restrictions which would impair the student from accurately reading gauges and calibrated equipment?  Yes  No If yes, please explain:

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**SECTION 3 – PHYSICIAN OR HEALTH CARE PROVIDER, carefully read the following statement, and check the appropriate boxes.**

I performed the above medical evaluation and found to the best of my knowledge, him/her to be free from physical or mental impairments, including habituation or addiction to depressants, stimulants, narcotics, alcohol or other behavior-altering substances which might interfere with the performance of his/her duties or would pose a potential risk to patients or personnel.

YES  NO

If NO is checked, please identify those problems which might interfere with the performance of his/her duties or would pose a potential risk to patients or personnel.

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\_\_\_\_\_  
PHYSICIAN'S/HEALTH CARE PROVIDER (WITH TITLE) SIGNATURE

\_\_\_\_\_  
PRINT PHYSICIAN'S/HEALTH CARE PROVIDER LAST NAME/STAMP

\_\_\_\_\_  
PHYSICIAN'S ADDRESS

\_\_\_\_\_  
OFFICE FAX # (IF APPLICABLE)

\_\_\_\_\_  
PHYSICIAN'S TELEPHONE NUMBER

\_\_\_\_\_  
DATE OF EXAM (Must be within one year of entering program)

**RETURN TO: MONROE COMMUNITY COLLEGE  
HEALTH SERVICES DEPARTMENT  
1000 EAST HENRIETTA RD.  
ROCHESTER, NY 14623-5780  
PHONE: 585-292-2018, FAX 585-292-3856**