



MEDICAL HISTORY REPORT

BINGHAMTON UNIVERSITY
STATE UNIVERSITY OF NEW YORK

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 the University Health Service and may not be released to anyone without your written consent.

University Health Service
PO Box 6000
Binghamton, New York 13902-6000
607-777-2221, Fax: 607-777-2881
health.binghamton.edu

Please indicate your date of entrance: 200__ Fall Spring Summer
Entering as: Freshman/Undergraduate Transfer/Undergraduate Graduate Full time Part time

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

PLEASE PRINT IN BLACK INK

Social Security or Student ID # _____

Name: Last _____ First _____ Middle _____ Birth date ____ / ____ / ____ Gender: M F
MO. DAY YR.

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) _____

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.

<p>Have you had:</p> <p>Allergy:</p> <p>Penicillin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Sulfonamides <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Serum <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Food (which) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Chest Pain/Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Communicable Diseases:</p> <p>Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Measles (rubeola) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Rubella (German measles) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Malaria <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Dental Problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p>	<p>Have you had:</p> <p>Diarrhea (recurrent) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Disease or Injury of Joints, Back <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Dizziness, Fainting <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Emotional Problems:</p> <p>Anxiety (frequent) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Depression (frequent) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Insomnia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Eye Problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Gallbladder/Gallstone Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Head Injury with Unconsciousness <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Headaches (frequent) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Heart Disease or Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Heart Palpitations <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Hernia, Rupture <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p>	<p>Have you had:</p> <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Respiratory Problems:</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Cough (chronic) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Ear, Nose, Throat Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Sinusitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Seizure Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Stomach or Intestinal Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p>	<p>Have you had:</p> <p>Surgery _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Tumor, Cancer, Cyst <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Urinary Tract Problems:</p> <p>Albumin/Sugar <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Frequent Urination <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Other <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Weakness, Paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Weight Gain or Loss (recent) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Females Only:</p> <p>Excessive Flow <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Irregular Flow <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p> <p>Severe Cramps <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/></p>
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REMARKS OR ADDITIONAL INFORMATION (Please list any routine medications.)

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

X _____
Student's signature Date

PLEASE PRINT IN BLACK INK

Social Security or Student ID# _____

Name: Last _____ First _____ Middle _____ Birth date: Mo. _____ Day _____ Yr. _____

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®) 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 University Health Service 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: 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	
		#1	#2		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 Mumps (1 dose of live vaccine on or after first birthday) and Rubella (1 dose of live vaccine on or after first birthday)	#1	#2					
								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 ____/____/____ or Tdap given ____/____/____ MO. DAY YR. MO. DAY YR.						
	Meningococcal vaccine	Menactra given ____/____/____ or Menomune given ____/____/____ MO. DAY YR. MO. DAY YR.						

An official record must be attached or this form must be signed by a medical care provider.

Signature of healthcare provider _____ Date _____

Address of healthcare provider _____ Phone # _____

PART C: TUBERCULOSIS RISK ASSESSMENT REQUIRED — SEE ENCLOSED FORM.

PART D: 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.

Date of physical exam ____/____/____ Blood pressure _____ Height _____ Weight _____ Vision: Right 20/____ Left 20/____
MO. DAY YR.

	Normal	Abn.	Explanation
Head, Ears, Nose, Throat			
Respiratory			
Cardiovascular			
Gastrointestinal			
Hernia			
Eyes			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			

corrected uncorrected

Is the 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 _____

Optional
Hemoglobin and/ Numerical values _____
or hematocrit Normal _____
Urine dipstick: Normal _____ Abnormal _____

Examiner's signature _____ (Collaborating MD name if NP/PA) _____

Print name and title _____ Registration # and state _____

Address _____ Telephone _____ Date _____