# ALL DORMITORY STUDENTS MUST COMPLETE THIS FORM

STUDENT HEALTH SERVICES
C.W. POST CAMPUS
LONG ISLAND UNIVERSITY

# REPORT OF MEDICAL HISTORY

Student: Please complete this page before going to your physician for examination.

| LAST NAME (print) | FIRST NAME | MIDDLE | SEX M F | DATE OF BIRTH | SOCIAL SECURITY NO. |
|---|---|---|---|---|---|
| | | | | | |

| HOME ADDRESS (Number & Street) | CITY OR TOWN | STATE | ZIP CODE | HOME TELEPHONE NO. |
|---|---|---|---|---|
| | | | | |

| NAME & ADDRESS OF EMERGENCY CONTACT | RELATIONSHIP | HOME TELEPHONE NO. | BUSINESS TELEPHONE NO. |
|---|---|---|---|
| | | | |

**FAMILY HISTORY**

| | AGE | STATE OF HEALTH | OCCUPATION | AGE OF DEATH | CAUSE OF DEATH |
|---|---|---|---|---|---|
| Father | | | | | |
| Mother | | | | | |
| Brother(s) | | | | | |
| | | | | | |
| | | | | | |
| Sister(s) | | | | | |
| | | | | | |
| | | | | | |

**Have any of your relatives had any of the following?**

| | YES | NO | RELATIONSHIP |
|---|---|---|---|
| Tuberculosis | | | |
| Diabetes | | | |
| Kidney Disease | | | |
| Heart Disease | | | |
| Arthritis | | | |
| Stomach Disease | | | |
| ☐ Asthma ☐ Hay Fever | | | |
| ☐ Epilepsy ☐ Convulsions | | | |

**PERSONAL HISTORY**

| HAVE YOU HAD: | Yes | No | | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Scarlet Fever | | | Insomnia | | | **Chest** | | | Gallbladder Trouble | | |
| Measles | | | Frequent Anxiety | | | ☐ Pain ☐ Pressure | | | or Gallstones | | |
| German Measles | | | Frequent Depression | | | Chronic Cough | | | Recurrent Diarrhea | | |
| Mumps | | | Worry or Nervousness | | | Palpitations (Heart) | | | ☐ Rupture ☐ Hernia | | |
| Chicken Pox | | | Recurrent Headache | | | High Blood Pressure | | | Recent Weight: | | |
| Malaria | | | Recurrent Colds | | | Low Blood Pressure | | | ☐ Gain ☐ Loss | | |
| ☐ Gum ☐ Tooth Trouble | | | Head Injury with Unconsciousness | | | Rheumatic Fever | | | ☐ Dizziness ☐ Fainting | | |
| Sinusitis | | | | | | Heart Murmur | | | ☐ Weakness ☐ Paralysis | | |
| Eye Trouble | | | ☐ Hay Fever ☐ Asthma | | | Joint Problems: | | | ☐ Epilepsy ☐ Convulsions | | |
| ☐ Ear ☐ Nose | | | Tuberculosis | | | Trick Knee | | | URINE: Sugar | | |
| ☐ Throat Trouble | | | Shortness of Breath | | | Shoulder | | | Albumin | | |
| **Surgery** | | | **Allergy** | | | Back Problems | | | Frequent Urination | | |
| Appendectomy | | | Penicillin | | | ☐ Tumor ☐ Cancer ☐ Cyst | | | Smoker - how many per day: | | |
| Tonsillectomy | | | Sulfonamides | | | Jaundice | | | **FEMALES ONLY** | | |
| Hernia Repair | | | Serum | | | Stomach Trouble | | | Irregular Periods | | |
| Other | | | Foods (which) | | | Intestinal Trouble | | | Severe Cramps | | |
| | | | Other | | | ☐ Diabetes ☐ Hypoglycemia | | | Excessive Flow | | |

**** IF YOU WEAR GLASSES, PLEASE ATTACH A COPY OF YOUR EYEGLASS PRESCRIPTION.**

| | | Yes | No |
|---|---|---|---|
| A | Has your physical activity been restricted during the past five years? (Give reasons and duration) | | |
| B | Have you had difficulty with school or teachers? (Give details) | | |
| C | Have you received treatment or counseling for a nervous condition, emotional problems, or substance abuse problems? (Give details) | | |
| D | Have you had any illness or injury or been hospitalized other than already noted? (Give details) | | |
| E | Have you consulted or been treated by clinics, physicians, healers or other practitioners within the past five years? (Other than routine checkups?) | | |

CHECK IF ANY APPLY:

_____ Wheelchair bound
_____ Use of braces or crutches
_____ Blind
_____ Visually impaired
_____ Deaf
_____ Hearing impaired
_____ Other handicap

Please briefly explain your special needs: _____

**ADDITIONAL COMMENTS**

Student's Signature _____ Date

Physician's Signature _____ Date

C.W. POST CAMPUS

LONG ISLAND UNIVERSITY

# ALL DORMITORY STUDENTS MUST SUBMIT THIS FORM COMPLETED BY DR.

## REPORT OF HEALTH EVALUATION

**To the Examining Physician:** Please review the student's history and complete the physician's form below. Comment on all positive answers. The information supplied will not affect his/her status; it will be used only as a background for providing health care if necessary. This information is strictly for the use of Student Health Services and will not be released without student consent. Please be sure to sign both sides of form.

M ☐ F ☐

STUDENT'S LAST NAME FIRST NAME MIDDLE SEX

STUDENT'S SOCIAL SECURITY NUMBER DATE OF BIRTH

**MANDATED BY NEW YORK STATE LAW**

The New York State Legislature has passed a law requiring all students attending colleges and universities in New York state who were born on or after **JANUARY 1, 1957**, to be immunized against **Measles, Mumps and Rubella.** Records should indicate **TWO** immunizations against **Measles** and **ONE** each against **Mumps and Rubella.** All immunizations must have been live vaccines — measles available **in 1968** and mumps available **in 1969**. All immunizations must have been given on or after the first birthday.

**IMMUNIZATIONS AND TESTS - Please give complete dates (Month/Day/Year)**

| | Dates of Immunization | Date of disease | Titre* |
|---|---|---|---|
| MMRs | 1st 2nd | | *(Must attach |
| Rubeola | 1st 2nd | | a copy |
| Mumps | | | of lab |
| Rubella | | Not acceptable | report) |
| Meningitis Vaccine | | | |
| Polio | | | |
| Tetanus Toxoid | | | |
| HBV | 1st 2nd 3rd | | |

**I HAVE EXAMINED THE FOLLOWING:**

| | FINDINGS: |
|---|---|
| 1. Head, Ears, Nose & Throat | |
| 2. Respiratory | |
| 3. Cardiovascular | |
| 4. Gastrointestinal | |
| 5. Hernia(s) | |
| 6. Eyes | |
| 7. Genitourinary | |
| 8. Musculoskeletal | |
| 9. Metabolic/Endocrine | |
| 10. Neuropsychiatric | |
| 11. Skin | |

**PPD (Mantoux) Test** (Mandatory)
Date administered: _____
Date read: _____ Results _____mm
(If Mantoux is positive, chest x-ray is required and report must be attached.)
Height _____ Weight _____
Blood Pressure _____
Vision: R _____ L _____ Corrected: R _____ L _____
Urinalysis: Micro _____ Sugar _____ Albumin _____
Hemoglobin (if indicated): _____gms%

Is there loss or seriously impaired function of any paired organ? No ☐ Yes ☐ _____
Recommendations for physical activity? Unlimited ☐ Limited ☐ Explain _____
Is the student taking any medication? No ☐ Yes ☐ Please list _____
I have examined the above patient and have found him/her physically fit to compete in intercollegiate sports. No ☐ Yes ☐
Have you any general comments? _____

Physician's Signature _____ Date _____
PRINT NAME _____
**ADDRESS & Office Stamp** _____
_____

**RETURN ALL INFORMATION TO:**
**Director, Student Health Services**
**LIU/C.W. Post Campus**
**720 Northern Blvd.**
**Brookville, NY 11548-1300**
**FAX: (516) 299-4113**

**REQUIRED**

**PARENTAL PERMIT**

The law requires that parental permission be obtained so that medical attention can be administered to minors. The following consent form should be signed by a parent so that procedures judged necessary may be conducted without undue delays. However, no major operation will be performed, except in extreme emergency, without the parents being contacted and fully informed.
I give my permission for such diagnostic and therapeutic procedures as may be deemed necessary for my son/daughter and also present information concerning his/her medical condition to other responsible College Officials when deemed necessary.

**Signed** _____ **Relationship** _____
Student is covered by: Hospitalization ☐ Medical Care ☐ Surgical Care ☐
If yes, give company _____ Policy No. _____

**STUDENT AFFIDAVIT:** I hereby certify that all the information entered is complete & accurate:

Student Signature: _____ Date: _____

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