# REPORT OF MEDICAL HISTORY 2010 – 2011

| Last/Family Name (Print) | First Name | Middle | Sex M ☐ F ☐ | Date of Birth (MM/DD/YYYY) |
|---|---|---|---|---|
| Home Address (Number & Street) | City or Town | | State | Zip Code |
| E-mail Address | Cell Phone | Social Security # | | RIN (Rensselaer ID # ) |
| Parent/Guardian/Emergency Contact | | Home Phone | | Business/Cell Phone |

Semester you will begin at Rensselaer: ☐ Fall ☐ Spring ☐ Summer Year _____ ☐ Freshman ☐ Transfer ☐ Graduate

Are you an exchange student? ☐ Yes ☐ No If so, what country? _____

Were you previously at Rensselaer? ☐ Yes ☐ No If so, what year? _____ Will you be enrolled in > 6 credits? ☐ Yes ☐ No

Do you plan on participating in intercollegiate sports? ☐ Yes ☐ No If yes, sport(s) _____

## ANNUAL HEALTH INSURANCE COVERAGE

**RPI MANDATES ALL STUDENTS TO HAVE HEALTH INSURANCE COVERAGE. STUDENTS ARE CHARGED THE HEALTH INSURANCE PREMIUM AUTOMATICALLY EACH SEMESTER FOR THE RPI/MAKSIN ANNUAL PLAN. THIS FEE MAY ONLY BE WAIVED IF:**

1. **THE STUDENT HAS COMPARABLE HEALTH INSURANCE COVERAGE (ROUTINE AND EMERGENCY CARE ARE REQUIRED IN TROY, NY AREA).**
2. **THE STUDENT MEETS THE WAIVER DEADLINE.**

**BEFORE YOU WAIVE/ENROLL: THIS PROCESS MUST BE DONE YEARLY!**

- **REVIEW THE RPI HEALTH INSURANCE COVERAGE INFORMATION ON www.maksin.com/rpi.aspx**
- **PLEASE CHECK WITH YOUR INSURANCE COMPANY TO MAKE SURE THEY PROVIDE COMPARABLE COVERAGE IN THE TROY, NY AREA (ROUTINE AND EMERGENCY CARE ARE REQUIRED).**

**TO WAIVE: DEADLINE DATES**

- **COMPLETE ONLINE WAIVER PROCEDURE THROUGH THE MAKSIN WEBSITE BY SEPTEMBER 15 FOR THE FALL/SPRING ANNUAL PLAN.**
- **SPRING WAIVERS (ONLY FOR JANUARY NEW FIRST-TIME REGISTERED STUDENTS) MUST BE SUBMITTED BY FEBRUARY 15**

**TO ENROLL:**

- **COMPLETE THE ONLINE ENROLLMENT PROCEDURE THROUGH THE MAKSIN WEBSITE BY THE ABOVE DEADLINES.**
- **AFTER ENROLLING, YOU WILL RECEIVE YOUR INSURANCE CARD IN THE MAIL AT THE ADDRESS YOU DESIGNATE.**

**** IF COVERED BY ANOTHER INSURANCE, PLEASE ATTACH A COPY OF BOTH SIDES OF YOUR INSURANCE CARD * (This doesn't constitute a waiver)***

**Due Date for This Form: June 15 for students enrolling for the Fall Semester**
**December 15 for students enrolling for the Spring Semester**

**Please Make Sure To Complete These Steps Before Returning This Form:** ***Keep a copy of this form for your records***

☐ Check to make sure that this form is filled out completely. **Pages 1 and 2 will be filled out by the student/parent**. Please make sure that the bottom of page 2 has been signed by the student if over 18 **or** the parent/guardian if student is under 18. Page 2 should be **reviewed** by your medical provider and **Pages 3 and 4 are to be filled out completely by your medical provider**.

☐ Make sure your physical is within the last 12 months and the form is complete and signed by your medical provider.

☐ Be sure all of your immunizations are complete and properly filled out including exact dates, copies of the results for any titers or chest x-rays performed and that all medical provider information is filled out.

☐ Review Health Insurance Information at **www.maksin.com/rpi.aspx**, Remember the online procedure is an **annual** process and needs to be completed whether you are waiving or enrolling in the insurance plan by the deadline listed above.

☐ IF COVERED BY ANOTHER INSURANCE, PLEASE ATTACH A COPY OF BOTH SIDES OF YOUR INSURANCE CARD **(you must still complete waiver online at the above site)**

IF THERE IS ANYTHING MISSING FROM YOUR FORM, IT WILL BE RETURNED VIA EMAIL. Please provide the best email address for us to contact you about missing information: _____

*If you would rather receive notification through postal mail, please check here* ☐

**For Office Use Only**

**Date reviewed** _____ **Initials** _____ **Sports Clearance** ☐ **Yes** ☐ **No** **Date reviewed** _____ **Initials** _____ **Cleared** ☐ **Yes** ☐ **No**

**Date reviewed** _____ **Initials** _____ **Sports Clearance** ☐ **Yes** ☐ **No** **Date reviewed** _____ **Initials** _____ **Cleared** ☐ **Yes** ☐ **No**

## Medical History

**Name:** _____

Are you currently taking any medications (including OTC and inhalers)? ☐ Yes ☐ No Please list: _____

_____

Are you taking any vitamin or herbal supplements? ☐ Yes ☐ No Please list: _____

Do you have any allergies to medications or environmental agents? ☐ Yes ☐ No Please list: _____

Alcohol Use ☐ Yes ☐ No Amount per week _____ Tobacco Use ☐ Yes ☐ No Amount per week _____

### Personal History: If you answer YES to any of these questions, please explain in the space provided below.

| Have you had? | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Anemia | | | Tumor | | | Surgery | | |
| Asthma | | | Thyroid Problem | | | Appendectomy | | |
| Bone or Joint Disease /Injury | | | Venereal Disease | | | Bone or Joint Surgery | | |
| Chicken Pox | | | Back Problems | | | Hernia Repair | | |
| Cancer | | | Chronic Cough | | | Tonsillectomy | | |
| Concussion /Head Injury | | | Dizziness or Fainting | | | Other | | |
| Diabetes | | | Eye, Ear, Nose or Throat Trouble | | | ADD/ADHD | | |
| Heart Disease | | | Frequent Urination | | | Anxiety | | |
| Hernia /Rupture | | | Gum or Tooth Trouble | | | Bipolar Disorder | | |
| Jaundice | | | Heat Cramps | | | Depression | | |
| Kidney Disease | | | Heart Murmur | | | Eating Disorder | | |
| Liver Disease /Hepatitis | | | High or Low Blood Pressure | | | Insomnia | | |
| Lyme Disease | | | Pain /Pressure in Chest | | | Substance Abuse /Dependency | | |
| Malaria | | | Palpitations (heart) | | | **FEMALES ONLY** | | |
| Mononucleosis /Epstein Bar Virus | | | Unexplained Weight Loss or Gain | | | Abnormal PAP Smear | | |
| Scarlet Fever | | | Recurrent Headaches | | | Endometriosis | | |
| Seizures | | | Shortness of Breath | | | Excessive Flow | | |
| Sickle Cell Disease | | | Stomach, Intestinal, Gallbladder | | | Irregular or Lack of Periods | | |
| Sinusitis | | | Weakness or Paralysis | | | Polycystic Ovarian Syndrome | | |
| Tuberculosis | | | Wheezing | | | Severe Cramps | | |

1. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years? ☐ Yes ☐ No
2. Have you had any illness or injury or been hospitalized other than already noted? ☐ Yes ☐ No
3. Are you missing any paired organ (i.e. kidney, testicles)? ☐ Yes ☐ No
4. Has your physical activity been restricted during the past five years? ☐ Yes ☐ No
5. Have you had back problems severe enough to cause you to stop regular activities for more than a day? ☐ Yes ☐ No
6. Have you been rejected/discharged from military service because of physical, emotional, or other reason? ☐ Yes ☐ No
7. Have you ever been cared for by a mental health clinician? ☐ Yes ☐ No
8. Have you ever been hospitalized for a mental health problem? ☐ Yes ☐ No
9. Would you like a referral to a psychiatrist and/or mental health clinician at RPI? ☐ Yes ☐ No

**Please answer <u>all</u> questions above. Comment below on <u>all</u> positive answers, including dates, reasons, and duration. Additional paper may be used.**

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### FAMILY HISTORY

| | Age | State of Health | Occupation | Age at Death | Cause of Death |
|---|---|---|---|---|---|
| Father | | | | | |
| Mother | | | | | |
| Brothers | | | | | |
| | | | | | |
| | | | | | |
| Sisters | | | | | |
| | | | | | |
| | | | | | |

### Have any of your relatives ever had the following?

| | Yes | No | Relationship |
|---|---|---|---|
| Arthritis | | | |
| Cancer | | | |
| Diabetes | | | |
| Heart Disease /Sudden death before age 55 | | | |
| High Blood Pressure | | | |
| High Cholesterol | | | |
| Kidney Disease | | | |
| Mental Illness | | | |
| Stomach or Intestinal Disease | | | |
| Tuberculosis | | | |

Your medical information is confidential and will not be released without your written consent. If you are under 18 years of age, your parents may have access to some of the data in your medical and counseling records. They will be notified if you are hospitalized. If you are over 18, it is your responsibility to inform your parents regarding your medical information.

- **If you are under 18 years of age, the following needs to be signed by your parent/guardian**
  I give permission for my son/daughter to be treated by the Student Health Center, including health and counseling services. I also authorize urgent or emergency treatment at Samaritan Hospital in Troy, NY Financial coverage for off-campus medical care is subject to your insurance plan limitations.
  Parent's/Guardian's Signature _____ Date _____
- **If you are over 18 years of age, please read and sign the following release.**
  In the event of serious physical or mental illness, I hereby consent to the notification of the person listed here on the emergency contact.
  Student's Signature _____ Date _____

# Physical Examination

***MUST BE WITHIN LAST 12 MONTHS. ALL INFORMATION IS REQUIRED AND MUST BE FILLED OUT BY A HEALTH CARE PROVIDER***

Name _____

**EXAM: (please address each area below)**

Height _____ Weight _____ BMI _____ BP _____ Pulse _____

Skin _____

Head _____

Eyes _____ Snellen R/20 _____ L/20 _____

Corrected R/20 _____ L/20 _____

Contact lens/glasses _____

Ears _____

Nose _____

Mouth and Throat _____

Neck _____

Thorax _____ Lungs _____

Breast _____

Spine/Back _____

Heart _____

Abdomen _____

Genito-urinary (testicles) _____

Extremities _____

Lymph Nodes _____

Reflexes _____

**Laboratory exam: (Optional)** HgB / Hematocrit _____ Urine Sugar _____ Urine Protein _____ Cholesterol _____

**Please answer all of the following questions**

- Does this student have a medical condition for which ongoing health care is required? ☐ Yes ☐ No
  Please describe, if yes. _____
  _____
- Does this patient use an inhaler prior to exercise? ☐ Yes ☐ No
- Is there any evidence of a heart murmur? ☐ Yes ☐ No If yes, has the murmur been evaluated by Echo? ☐ Yes ☐ No
- Has the murmur been determined by workup to be benign and not interfere with activity? ☐ Yes ☐ No
- Has this patient had a history of serious head injury/concussion? ☐ Yes ☐ No
  Please describe, if yes. _____
  If more than one (1) concussion, how many and when was the last? _____
- Are there any restrictions or contraindications to athletics? ☐ Yes ☐ No
  Please describe. _____
- Are there any special braces or pads to be worn for sports? ☐ Yes ☐ No
  Please describe, if yes. _____
- This patient is in good physical condition and may participate in unlimited physical activity, including contact varsity level sports, non-contact varsity level sports, intramurals, and ROTC. ☐ Yes ☐ No
  If no, please describe _____
  _____

Recommendations for the physical and mental health care at RPI? _____

_____

_____

Signature of the Health Care Provider _____ Date of Exam _____

Health Care Provider's Name _____

Address _____

Telephone Number ( _____ ) _____ – _____ Fax Number ( _____ ) _____ – _____

***Stamp may be used, but must be accompanied by signature and date**

Student Name _____ Student ID _____ – _____ – _____ SSI _____ – _____ – _____ Date of Birth ___ / ___ / ____

## Immunization Verification: Must be completed by a healthcare professional in its entirety in English prior to Registration.

**Required Immunizations: PLEASE SUBMIT DATES IN MM/DD/YYYY FORMAT**

| | |
|---|---|
| **MMR** (combined measles, mumps, rubella) – **NYS Health Department Law**<br>• **TWO** doses required after 1st birthday and at least 28 days apart and after 01/01/1968 | Dose # 1 ___ /___ /____<br>Dose # 2 ___ /___ /____ |
| **MEASLES** (if MMR not given): **ONE** of the following is **required — NYS Health Department Law**<br>• **TWO** doses required after 1st birthday and at least 28 days apart and after 01/01/1968<br>• **OR** Titer(blood test, serology) confirming immunity — **MUST ATTACH LAB RESULTS** | Dose # 1 ___ /___ /____<br>Dose # 2 ___ /___ /____<br>Titer ___ /___ /____ Result _____ |
| **MUMPS** (if MMR not given): **ONE** of the following is **required — Rensselaer Requirement**<br>• **TWO** doses required after 1st birthday and after 01/01/1968<br>• **OR** Titer (blood test, serology) confirming immunity — **MUST ATTACH LAB RESULTS** | Dose # 1 ___ /___ /____<br>Dose # 2 ___ /___ /____<br>Titer ___ /___ /____ Result _____ |
| **RUBELLA** (if MMR not given): **ONE** of the following is **required — NYS Health Department Law**<br>• **ONE** dose required after 1st birthday and after 01/01/1968<br>• **OR** Titer (blood test, serology) confirming immunity — **MUST ATTACH LAB RESULTS** | Dose # 1 ___ /___ /____<br>Titer ___ /___ /____ Result _____ |
| **MENINGITIS — Rensselaer Requirement for students 34 years old and under**<br>• Menactra after 2005 is acceptable, (Menomune must be within the past 3-5 years) | Type _____<br>Date ___ /___ /____ |
| **TETANUS/DIPHTHERIA** circle one (DTP, Td, DT, TDaP) — **Rensselaer Requirement**<br>• Required booster within last 10 years | Type _____<br>Date ___ /___ /____ |

**Strongly Recommended Immunizations: (All immunizations are available at the Student Health Center, excluding Varicella)**

| | |
|---|---|
| **GARDISIL**<br>• There are THREE doses for this vaccine<br>• 2nd dose 2 months from initial dose, 3rd dose 6 months from initial dose | Dose # 1 ___ /___ /____<br>Dose # 2 ___ /___ /____<br>Dose # 3 ___ /___ /____ |
| **HEPATITIS A**<br>• There are TWO doses for this vaccine<br>• 2nd dose 6-12 months after initial dose | Dose # 1 ___ /___ /____<br>Dose # 2 ___ /___ /____ |
| **HEPATITIS B**<br>• There are THREE doses for this vaccine<br>• 2nd dose 1 month from initial dose, 3rd dose 6 months from initial dose | Dose # 1 ___ /___ /____<br>Dose # 2 ___ /___ /____<br>Dose # 3 ___ /___ /____ |
| **VARICELLA** (Chicken Pox) Vaccination/Disease<br>• There are TWO doses for this vaccine<br>• Need to be given at least 28 days apart | Dose # 1 ___ /___ /____<br>Dose # 2 ___ /___ /____ OR<br>Date of Disease ___ /___ /____<br>Titer ___ /___ /____ Result _____ |

**TUBERCULOSIS SCREENING NOTE: The countries listed below are WITHOUT endemic TB. Students from these countries should complete section A (see boxed areas below).**

AMERICAN REGION: USA, Bermuda, British Virgin Islands, Canada , Cayman Islands, Chile, Costa Rica, Cuba, Jamaica, Saint Kitts and Nevis, Puerto Rico, Saint Lucia, Trinidad, Virgin Islands.
EUROPEAN REGION: Albania, Belgium, Cyprus, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Slovakia, Slovenia, Sweden, Switzerland, United Kingdom.
WESTERN PACIFIC REGION: American Samoa, Australia, New Zealand. MIDDLE EAST REGION: Israel, Jordan, Lebanon, United Arab Emirates.

**A:**

1) Does this student have HIV? ☐ Yes ☐ No
2) Has this student been in close contact with anyone with active TB? ☐ Yes ☐ No
3) Was this student born in, or lived in, any countries that are not on the above list for more than 1 month? ☐ Yes ☐ No
4) Does the student have persistent cough with night sweats, loss of weight, fatigue or fever? ☐ Yes ☐ No

**If any "yes" answers, then complete section B**

**B: * REQUIRED FOR ALL STUDENTS NOT LISTED ABOVE:**

| | |
|---|---|
| Mantoux (PPD) Skin Test: Must be performed in the US or Canada and you must submit date placed, date read and induration in mm even if 0. May submit attached copy of Quantiferon Gold blood Test instead of PPD. | Date Placed_____<br>Date Read_____<br>PPD Result _____ mm ____ |
| **If PPD (> 10mm in most cases) or Quantiferon is Positive,** you must submit copy of CXR report. CXR must be done in US or Canada and be done in the past 12 months.<br>1.Treatment received for positive PPD? ☐ Yes ☐ No<br>2.Treatment was discussed and declined? ☐ Yes ☐ No | CXR Result_____<br>Date ___ /___ /___<br>Medications Taken (if any)<br>_____ and Dates taken<br>___ /___ /____ to ___ /___ /____ |

***May have PPD placed at the Health Center if unable to obtain in US before arrival, but send form now.**

Health Care Professional: By signing below, you attest that all information supplied in this section is true and correct to the best of your knowledge.

Date _____

Signature of the Health Care Provider _____

Health Care Provider's Name _____

Address _____

Telephone Number ( _____ ) _____ – _____ Fax Number ( _____ ) _____ – _____

***Stamp may be used, but must be accompanied by signature and date**

Rensselaer

**Return all information to**
**Student Health Center – RPI**
**110 8th Street – 3200 Academy Hall**
**Rensselaer Polytechnic Institute, Troy, NY 12180**
**(518) 276-6287 Fax (518) 276-8573**
**healthrecords@rpi.edu**



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