COLLEGE OF
MOUNT SAINT VINCENT

HEALTH CENTER
6301 Riverdale Avenue, Riverdale NY 10471
Phone: 718.405.3240 FAX: 718.405.3737

Student's Name_____ _____/_____/_____
(PRINT) LAST NAME FIRST NAME DATE OF BIRTH

Student's Cell Phone _____ Home Phone _____ CMSV ID _____

Name of next of kin_____ Relationship_____

Address _____ Phone _____

PHYSICAL EXAMINATION FORM

PERSONAL HISTORY Do you have now or have you ever had any of the following? Please check all that apply.

1. ☐ Anemia	**10. ☐ Deaf/Hearing impairment**	**19. ☐ Injury / Disease of Bones**	**28. ☐ Sinusitis**
2. ☐ Anorexia / Bulimia	**11. ☐ Depression**	**20. ☐ Kidney Disease**	**29. ☐ Strep Throat**
3. ☐ Anxiety	**12. ☐ Diabetes**	**21. ☐ Lupus / SLE**	**30. ☐ Surgery**
4. ☐ Asthma	**13. ☐ Emotional/Mental Illness**	**22. ☐ Migraines / Headaches**	**31. ☐ Thyroid Disease**
5. ☐ Blind/visual impairment	**14. ☐ Heart Murmur/ Palpitations**	**23. ☐ Neuromuscular Disease**	**32. ☐ TB Disease**
6. ☐ Cancer / malignancy	**15. ☐ Hepatitis**	**24. ☐ Phlebitis / Deep Vein Clot**	**33. ☐ Ulcer / Stomach**
7. ☐ Celiac Disease	**16. ☐ High/Low Blood Pressure**	**25. ☐ Positive TB Test**	**34. ☐ Unconsciousness**
8. ☐ Chest pain / pressure	**17. ☐ High Cholesterol**	**26. ☐ Seizure disorder**	**35. ☐ Weakness**
9. ☐ Cystic fibrosis	**18. ☐ Impaired mobility / paralysis**	**27. ☐ Sickle Cell Disease / Trait**	**36. ☐ Other_____**

PLEASE EXPLAIN ALL POSITIVE ANSWERS (with dates): _____

_____

CURRENT MEDICATIONS: *List:*_____

ALLERGY: TO MEDICATION: ☐ Penicillin ☐ Sulfur ☐ Other Medication (name)_____

☐ ENVIRONMENTAL ☐ FOODS (name)_____

EPI-PEN: HAVE YOU EVER NEEDED IT? ☐ YES ☐ NO DO YOU CARRY EPI-PEN? ☐ YES ☐ NO

	Age	State of Health	Occupation	Living	Age of Death	Cause of Death
Father						
Mother						
Brothers						
Sisters						

FAMILY HISTORY: *List* family members with health problems: i.e. cancer, diabetes, heart disease, Marfan Syndrome,

_____

_____

Please see other side for Physical Exam Report to be completed by MD or NP

Student's Name_____ _____/_____/_____
(PRINT) LAST NAME FIRST NAME DATE OF BIRTH

Vision: R 20/_____ L 20/_____ **Corrected Vision: R 20/_____ L 20/ _____**

Height:_____ Weight:_____ **BP:_____ Pulse:_____**

Tuberculosis Test: PPD

Date placed: _____/_____/_____

Date read: **_____/_____/_____**

Result: _____mm.induration

Urinalysis:

Glucose____ Protein_____

Leucocytes_____Blood_____

Chest X-ray (if PPD Positive) attach typed X-ray copy

Date of Chest X-ray _____

Result of Chest X-ray _____

Student receiving therapy:_____

☐ Yes ☐ No ☐ Refused

Immunization Dates:

. Tdap _____

Td _____

Attach Immunization record for other Vaccines received

SYSTEM	NORMAL	DESCRIBE ABNORMALITY
Anemia (type)		
Cardiovascular		
Chest and Breasts		
Gastrointestinal		
Genitourinary		
HEENT		
Metabolic / Endocrine		
Musculoskeletal		
Neurological		
Psychological		
Respiratory		
Skin		

CURRENT & CHRONIC PROBLEMS: _____

_____

PLEASE ATTACH ADDITIONAL CLINICAL REPORTS TO ASSIST US IN PROVIDING CONTINUITY OF CARE.

RECOMMENDATIONS FOR PHYSICAL ACTIVITY: ☐ Unlimited ☐ Limited (specify):_____

PHYSICIAN OR NP's SIGNATURE: _____

PRINT PHYSICIAN or NP's NAME: _____

State / License #_____ Date of Physical Exam:_____

Address_____ Date Form Signed: _____

Use Office Stamp:

MAIL COMPLETED FORM TO:
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MOUNT SAINT VINCENT
Health Center
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Riverdale NY 10471