



# HEALTH FORM

Health Service - Founders Hall  
2 Convent Rd., Morristown, NJ 07960  
Tel# 973-290-4175 Fax# 973-290-4182

## IDENTIFICATION DATA

Name \_\_\_\_\_  
Last First Middle date of birth

Home Address \_\_\_\_\_  
Street City State Zip Code

State/Country of Origin \_\_\_\_\_ tel # \_\_\_\_\_  
home cell

First Semester Enrolled \_\_\_\_/\_\_\_\_ Women's College Freshman  Transfer  Resident   
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## HEALTH INSURANCE COVERAGE

Insurance Company Address Group and Policy#

Subscriber's Name Subscriber's DOB Subscriber's SS #

## EMERGENCY INFORMATION - contact to be notified in case of emergency

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Address \_\_\_\_\_ tel.# \_\_\_\_\_  
Home work/cell

Please list another person who can be contacted in case the above person cannot be reached.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Tel.# \_\_\_\_\_

## PARENTAL ENDORSEMENT FOR MEDICAL CARE

Permission for medical care of minors (A parent's or guardian's signature is required)

For students under the age of 18: I hereby give permission to the medical and psychological staff of College of St. Elizabeth Health Services to examine and treat my minor child for all medical problems and injuries that may occur while he or she is at the College of St. Elizabeth.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

## SOURCES OF HEALTHCARE

List the names, addresses and telephone numbers of Physicians, psychologists, or other health care providers you now consult.

Name/specialty
Address
City, State
Telephone Fax

Name/specialty
Address
City, State
Telephone Fax

Name/specialty
Address
City, State
Telephone Fax

College of St. Elizabeth  
**Health History Questionnaire**  
 Completed by student, reviewed by physician

Name: \_\_\_\_\_

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

*Answer ALL questions Explain All YES Answers*

<b>ALLERGY</b>	<b>Yes</b>	<b>No</b>
Any significant allergy to food, medications, insects, pollen?	<input type="checkbox"/>	<input type="checkbox"/>
List known allergies and type of reaction to them:		
Medication.....	<input type="checkbox"/>	<input type="checkbox"/>
Food.....	<input type="checkbox"/>	<input type="checkbox"/>
Environmental.....	<input type="checkbox"/>	<input type="checkbox"/>

**MEDICATIONS:**  
 Do you take any medications regularly, including herbals, supplements and over the counter drugs?

Medications: List all medications and dosage that you take regularly prescription and non prescription (ex. Anxiety, ADD, depression, birth control, asthma, etc.)

**HOSPITALIZATION:**

Have you ever been admitted to a hospital?

Have you ever had surgery?

Have you ever had any ER visits?

**PAST ILLNESSES**

Hepatitis, mononucleosis, childhood diseases, HIV

Loss of absence of any body parts.

Severe/frequent colds or flu

**EENT**

Any problems with you eyes, ears, nose or throat?

Hearing impairment

Loss of eye or eyesight

**CARDIOVASCULAR:**

Heart murmur/ palpitations

Chest pain

Rheumatic fever

High blood pressure

Irregular heartbeat

Blood clots (not menstrual clots)

Enlarge heart

Mitral valve prolapse

Fainting

**RESPIRATORY:**

	<b>Yes</b>	<b>No</b>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chest infection (pneumonia)	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>
How many?__How long?__		
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>

**SKIN**

	<b>Yes</b>	<b>No</b>
Any problems with your skin?	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>

**ENDOCRINE**

Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>

**URINARY**

Impaired function of any part of your urinary tract

Loss of a kidney

Recurrent urinary infection

Kidney Infection

Kidney stones

**MENTAL HEALTH**

Any problems with your emotional health, requiring any form of therapy, including medications?

Did you ever lie to anyone about your gambling?

Does anyone presently in your life hurt you or makes you feel afraid?

**DRUG AND ALCOHOL USAGE**

Have you ever felt you should cut down on your drinking?

Have people annoyed you by criticizing your drinking?

Have you ever had a drink first thing in the morning to steady your nerves or rid of a hangover?

Please give specific information about drug usage (ex. Marijuana, pain medication, ecstasy)

**BLOOD:**

	Yes	No
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Sickle-cell disease	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding or bruising	<input type="checkbox"/>	<input type="checkbox"/>

**HEALTH AND NUTRITION**

	Yes	No
Are you following a special diet?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>

**BONE AND JOINT**

Any serious disability deformity or disease of bone, joint, or muscle?	<input type="checkbox"/>	<input type="checkbox"/>
Injury, neck, shoulder, back, knee, ankle, other	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>

**REPRODUCTIVE SYSTEM (men):**

Prostate trouble	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of the scrotum or testicle	<input type="checkbox"/>	<input type="checkbox"/>
Undescended or absent testicle	<input type="checkbox"/>	<input type="checkbox"/>
Do you perform testicular self examination?	<input type="checkbox"/>	<input type="checkbox"/>
History of sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>

**NEUROLOGY**

Concussion/head injury	<input type="checkbox"/>	<input type="checkbox"/>
Seizures or convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Fainting or blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>

**REPRODUCTIVE SYSTEM (women):**

Never had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
Any form of menstrual disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Do you perform breast self-exam?	<input type="checkbox"/>	<input type="checkbox"/>
Last menstrual period _____		
Abnormal PAP	<input type="checkbox"/>	<input type="checkbox"/>
History of sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>

**GASTROINTESTINAL**

Problems with any part of your intestinal tract or stomach?	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice/hepatitis/gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Acid reflex	<input type="checkbox"/>	<input type="checkbox"/>
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>

**ACCIDENT PREVENTION**

Do you usually wear a seat belt when you ride in car?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear protective equipment when participating in a sports act?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink and drive?	<input type="checkbox"/>	<input type="checkbox"/>

*Additional Explanations:*

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**FAMILY HISTORY completed by student**

Check the following conditions which have appeared in your immediate family, indicating the person's relationship to you. (Ex. Father Cancer)

_____ Allergies	_____ Heart Disease	_____ Mental Illness
_____ Asthma	_____ Sudden death before age 50	_____ Tuberculosis
_____ Cancer or Tumor	_____ Stroke	_____ Gyn. Disorders
_____ Diabetes	_____ Kidney Disease/Bladder Disease	_____ Rheumatology
_____ High Blood Pressure	_____ Thyroid Disease	_____ Seizure
_____ High Cholesterol	_____ Alcoholism/Drug Abuse	_____ Migraine

Are your parents living? \_\_\_\_\_ # of brother's livings \_\_\_\_\_ # of sisters living \_\_\_\_\_

If deceased, give relationship and cause of death \_\_\_\_\_

***To the Student: I certify that the statements are true to the best of my knowledge.***

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

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

History Reviewed by Physician- Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

College of St. Elizabeth Health Service

**Physical Examination**

**Health History must be reviewed by the physician**

Physical exam to be completed by the physician and performed **WITHIN ONE YEAR** prior to entrance to the College

Patient Name \_\_\_\_\_ Sex M/F Date of Birth \_\_\_\_\_ **DATE OF EXAM** \_\_/\_\_/\_\_

Vision: *uncorrected* Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_; *with glasses/contacts* Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_

Hearing: normal  Yes  No Abnormal \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ P \_\_\_\_\_ Resp \_\_\_\_\_

System	Satisfactory	Describe Abnormality
Eyes		
Ears		
Nose, throat		
Neck, thyroid		
Chest, lungs		
Breast		
Heart		
Abdomen, liver, kidneys, spleen		
Lymphatics		
Hernia		
Genitalia		
Pelvic (if indicated)		
Rectal		
Extremities, back, spine		
Skin		
Joints		
Neurological		
Psychological		

Laboratory Tests: URINALYSIS Protein \_\_\_\_\_ Glucose \_\_\_\_\_ Blood \_\_\_\_\_  
 BLOOD T. Cholesterol (Fasting) \_\_\_\_\_ CBC \_\_\_\_\_  
 Additional labs as indicated \_\_\_\_\_

Impression/Plan Recommendations, continuing treatment, restriction, medications should be noted : (attached as needed):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Applicant may participate in College activities: including sports, physical education and intramurals

- Without restriction  
 With the following restrictions and reason: \_\_\_\_\_  
 \_\_\_\_\_

**History Reviewed & Student Examined by:**

Physician name (print): \_\_\_\_\_

Date \_\_/\_\_/\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_