REQUIRED FORM A – HEALTH FORM (4 PAGES) – WOMEN'S COLLEGE

Health Services - Founders Hall - 2 Convent Road - Morristown, NJ 07960
Phone Number: 973-290-4132, 4175 Fax Number: 973-290-4182 Immunization Information Number: 973-290-4388

IDENTIFICATION DATA

Name_____ _____
Last /Maiden name First Middle Date of Birth

Home Address_____
Street City State Zip Code

State/Country of Origin_____ Telephone _____
home cell

First Semester Enrolled ___/___ Expected Graduation Date ___/___ Freshman ____ Transfer ____
M/Y M/Y

CSE Leave Of Absence ____/____ CSE Withdrawal ____/____ CSE Dismissal ____/____
M/Y M/Y M/Y

HEALTH INSURANCE COVERAGE

Please include a copy of your **present health insurance card front and back.**

_____
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

College of St. Elizabeth
Health History Questionnaire
Completed by student and physician

Name: _____ Date of Birth: _____

Answer ALL questions ***Explain All YES Answers***

ALLERGY

	Yes	No
Any significant allergy to food, medications, insects, pollen?	☐	☐
List known allergies and type of reaction to them:		
Medication	☐	☐
Food	☐	☐
Environmental	☐	☐
Vaccines	☐	☐

_____
_____
_____

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, diabetes etc.)

_____
_____
_____

HOSPITALIZATION:

Have you ever been admitted to a hospital?	☐	☐
Have you ever had surgery?	☐	☐
Have you ever had any ER visits?	☐	☐
Have you ever had any severe injury?	☐	☐

List:

_____
_____
_____

PAST ILLNESSES

Hepatitis, mononucleosis, childhood diseases,	☐	☐
HIV	☐	☐
Loss or absence of any body parts.	☐	☐
Severe/frequent colds or flu	☐	☐
Serious illness or injury	☐	☐

_____
_____
_____

EENT

Any problems with your 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)	☐	☐
Enlarged heart	☐	☐
Mitral valve prolapse	☐	☐
Fainting	☐	☐

_____
_____
_____

RESPIRATORY:

	Yes	No
Asthma	☐	☐
Tuberculosis	☐	☐
Chest infection (pneumonia)	☐	☐
Do you smoke cigarettes?	☐	☐
How many? __ How long? ___		
Shortness of breath	☐	☐
Wheezing	☐	☐
Chronic cough	☐	☐

_____
_____

SKIN

	Yes	No
Any problems with your skin?	☐	☐
Skin rashes	☐	☐
Acne	☐	☐
Eczema	☐	☐

_____ _____
_____

ENDOCRINE

Thyroid disease	☐	☐
Diabetes	☐	☐

_____
_____
_____

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 make you feel afraid?	☐	☐
History of depression?	☐	☐
History of self harm or harm to others?	☐	☐
History of abuse physically, emotionally or sexually?	☐	☐
Learning disabilities?	☐	☐

_____
_____
_____

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 you of a hangover?	☐	☐
Smoke cigaretts?	☐	☐

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

_____
_____

Name: _____

BLOOD:	Yes	No
Anemia	☐	☐
Sickle-cell disease/trait	☐	☐
Abnormal bleeding or bruising	☐	☐

BONE AND JOINT

Any serious disability, deformity or disease of bone, joint, or muscle?	☐	☐
Injury, neck, shoulder, back, knee, ankle, other	☐	☐
Arthritis	☐	☐

NEUROLOGY

Concussion/head injury	☐	☐
Seizures or convulsions	☐	☐
Fainting or blackouts	☐	☐
Dizziness	☐	☐
Recurrent headaches	☐	☐
Migraines	☐	☐

GASTROINTESTINAL

Problems with any part of your intestinal tract or stomach?	☐	☐
Jaundice/hepatitis/gallbladder disease	☐	☐
Hernia	☐	☐
Ulcer	☐	☐
Acid reflex	☐	☐
Irritable bowel syndrome	☐	☐
Inflamitory bowel disease	☐	☐

HEALTH AND NUTRITION	Yes	No
Are you following a special diet?	☐	☐
Do you have an eating disorder?	☐	☐
Unexplained weight loss / gain?	☐	☐

REPRODUCTIVE SYSTEM (men):

Prostate trouble	☐	☐
Swelling of the scrotum or testicle	☐	☐
Undescended or absent testicle	☐	☐
Do you perform testicular self examination?	☐	☐
History of sexually transmitted disease	☐	☐

REPRODUCTIVE SYSTEM (women):

Never had a menstrual period?	☐	☐
Any form of menstrual disorder?	☐	☐
Do you perform breast self-exam?	☐	☐
Last menstrual period _____		
Abnormal PAP	☐	☐
History of sexually transmitted disease	☐	☐
History of pregnancy?	☐	☐

ACCIDENT PREVENTION

Do you usually wear a seat belt when you ride in car?	☐	☐
Do you wear protective equipment when participating in a sports act?	☐	☐
Do you drink and drive?	☐	☐

Additional Explanations:

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
_____ Asthma
_____ Bleeding problems
_____ Cancer or Tumor
_____ Diabetes
_____ High Blood Pressure
_____ High Cholesterol
_____ Migraine
_____ Sickle cell anemia / trait
_____ Heart Disease
_____ Sudden death before age 50
_____ Stroke
_____ Kidney Disease / Bladder Disease
_____ Thyroid Disease
_____ Alcoholism / Drug Abuse
_____ Learning disability
_____ Depression
_____ Mental Illness
_____ Tuberculosis
_____ GYN Disorders
_____ Rheumatology
_____ Seizure

Are your parents living? _____# of brothers living _____# of sisters living _____

If deceased, give relationship and cause of death and age of death _____

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

Student Signature: _____print name_____ 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 _____ Peak Flow (as indicated)_____

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

Laboratory Tests: URINALYSIS _____
BLOOD Cholesterol (Fasting) _____ CBC _____ Sickle Trait Screening (for athletes)_____
Additional labs as indicated _____
Include copy of lab results

Impression/Diagnosis/Plan: recommendations, continuing treatment, restriction, medications should be noted : (attach 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 _____