**Manhattan College Health Services**

**History & Physical**

**Name: Date of Birth: Age: \_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_ ID # \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Address: Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Veteran (Branch & Dates) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you have Health Insurance? Y or N (circle one) Please complete the insurance enroll/waiver form on the Health Services website.

**Date of Physical Exam** (within one year)**: \_\_\_\_\_\_\_\_** \*(for Undergraduates)

**(Athletes need to complete NCAA physical form. See Sports Medicine Webpage at gojaspers.com)**

***Personal Medical History - Please circle all below that apply to you* ** *Check here if none apply*

Alcohol/drug abuse Dental Problem Mononucleosis

Anxiety/depression/mental illness Diabetes Rheumatic Fever

Asthma Endometriosis Seizures

Cancer Gastrointestinal Problems Sickle Cell Anemia

Cardiac Condition/Heart Murmur Hepatitis B or C Disease Thyroid Disorder

Coagulation Disorder High Blood Pressure Tuberculosis

Concussion HIV/AIDS Other please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Family History*** | | | | |
|  | Age | State of Health | Age of Death | Cause of Death |
| Father |  |  |  |  |
| Mother |  |  |  |  |
| Siblings |  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**SIGNIFICANT MEDICAL HISTORY: SURGICAL HISTORY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Height: Weight: BP: Pulse:

\*\*Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*Allergies (medication, environmental, foods): Epi-pen needed? Y or N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **System** | **Normal** | **Describe Abnormality** |
| Skin |  |  |
| HEENT |  |  |
| Lungs / Chest |  |  |
| Heart / Vascular System / \*Athletes: Heart murmur evaluation |  |  |
| Abdomen (recital if indicted) |  |  |
| Genito-urinary |  |  |
| Pelvic (if indicted) |  |  |
| Musculoskeletal |  |  |
| Neurological |  |  |
| Psychological |  |  |
| Other:  \*Athletes: Femoral pulses Marfan syndrome |  |  |

**Patient is FULLY CLEARED to Participate in Activities / Sports including Division 1 without ANY Restrictions.**

**YES or NO (circle one)**

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

**Signature (MD, DO, NP, PA): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Provider Name & Office Stamp:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_