

Please return completed form to: **Siena College Health Service 515 Loudon Road, Loudonville, NY 12211**

SIENA COLLEGE HEALTH RECORD

Please complete pages 1 & 2, and review the information with your health care provider prior to your physical exam.

LAST NAME (PRINT) FIRST NAME MIDDLE SS#

HOME ADDRESS (NUMBER AND STREET) CITY OR TOWN STATE ZIP CODE DOB

(AREA CODE) HOME TEL. NUMBER (AREA CODE) CELL NUMBER

EMERGENCY CONTACT: NAME/RELATIONSHIP (AREA CODE) CELL NUMBER

EMERGENCY CONTACT HOME ADDRESS (AREA CODE) HOME TEL. NUMBER

LIST OF ALL COLLEGES YOU HAVE ATTENDED AND DATES CITIZENSHIP

MARITAL STATUS (circle one) S M OTHER // MALE___ FEMALE___ // _____

CLASS YOU ARE ENTERING

FAMILY HISTORY					Have any of your relatives had any of the following?	YES	NO	Relationship
Age	State of Health	Occupation	Age at Death	Cause of Death				
Father					Tuberculosis			
Mother					Diabetes			
Brothers					Kidney Disease			
					Heart Disease			
					Arthritis			
Sisters					Stomach Disease			
					Asthma, Hay Fever			
					Epilepsy, Seizures			
					Cancer			

PERSONAL HISTORY: PLEASE ANSWER ALL QUESTIONS

HAVE YOU HAD?	YES	NO	HAVE YOU HAD?	YES	NO
Chicken Pox			Inflammatory Bowel Disease		
Ear Problems/Hearing Loss			Kidney/Bladder Infection		
Eye Problems			Sexually Transmitted Disease		
Sinusitis			Menstrual Disorder		
Recurrent Headaches			Depression		
Head Injury with unconsciousness			Anxiety Disorder		
Recurrent Strep Throat			Seizure Disorder		
Thyroid Disorder			Cancer		
Asthma			Diabetes		
Pneumonia			Sickle Cell/ Sickle Cell Trait		
Heart Murmur			Anemia		
Mitral Valve Prolapse			Joint Injury		
High Blood Pressure			Back Problems		
Stomach Ulcers			Mononucleosis		
Hepatitis (A, B, C)			Other		
Irritable Bowel					

PROVIDE COMMENTS ON ALL "YES" ANSWERS IN SPACE BELOW:

PLEASE COMPLETE THE FOLLOWING:

Hospitalizations or Operations (give dates & procedures) _____

Serious Injuries (including fractures, motor vehicle accidents, etc.) _____

Counseling for Emotional Disorders/Psychiatric Treatment/Drug or Alcohol Rehabilitation _____

Allergies (medications, food, environment; i.e., insects, chemicals, animals) _____

Medications: _____

Tobacco type/amount: _____

Alcohol use/amount: _____

THE INFORMATION I HAVE PROVIDED IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

STUDENT SIGNATURE DATE

PARENT SIGNATURE (if student is under 18 years of age) DATE

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FOR OFFICE USE ONLY

Health Record Complete Medical History Incomplete Consent for Minors Incomplete
Immunizations Incomplete Physical Exam Incomplete Letter Sent Date _____

Reviewed by: _____ Date record complete _____
(RN Signature)

Entered by _____

FORM MUST BE COMPLETED BY A NON-PARENTAL HEALTH CARE PROVIDER

REPORT OF PHYSICAL EXAM

NAME: _____ DOB: _____

Number of years known to examiner _____ HEIGHT: _____ WEIGHT: _____

TEMP. _____ PULSE _____ BLOOD PRESSURE _____ HEARING:RIGHT _____ LEFT _____ HEARING AID _____

VISION: RIGHT20/ _____ LEFT 20/ _____ CORRECTED: RIGHT 20/ _____ LEFT 20/ _____ GLASSES/CONTACTS _____

NORMAL	ABNORMAL	PLEASE CHECK EACH ITEM:	PLACE ITEM NUMBER BEFORE EACH COMMENT
		1. Head, neck, face, scalp	
		2. Nose and sinuses	
		3. Mouth and throat	
		4. Teeth and gingival	
		5. Ears	
		6. Eyes (lids, conjunctiva, pupils, etc.)	
		7. Chest and lungs	
		8. Heart (estimate of cardiac function)	
		9. Vascular system (varicosities)	
		10. Abdomen and Viscera (hernia)	
		11. Ano-rectal and pilonidal	
		12. Endocrine system	
		13. GU system	
		14. Spine and musculoskeletal	
		15. Upper and lower extremities	
		16. Skin and lymphatics	
		17. Neurologic	

LAB: Urinalysis: Alb. _____ Glucose _____ Blood _____ Micro _____ ; HCT or HGB _____

SPECIAL DIETARY REQUIREMENTS: _____

ALLERGIES: _____

MEDICATIONS: _____

SUMMARY OF ABNORMALITIES, RECOMMENDATIONS, INCLUDING EMOTIONAL STATUS:

(Please let us know if you have any concerns, both physical and emotional, about this student, that you would like to share with us)

TUBERCULOSIS SCREENING

1. Does the student have signs or symptoms of active TB disease ____ YES ____ NO

If NO, proceed to question 2.

If YES, proceed to Page 4, Tuberculosis Testing.

2. Is the student a member of a high-risk group* (See CDC criteria on Page 4) ____ YES ____ NO

If NO, stop. No further evaluation is needed at this time.

If YES, place tuberculin skin test. A history of BCG vaccination should not preclude testing of a member of a high-risk group.

If there is a history of a past positive TB test, a chest x-ray is required; Proceed to Page 4

HEALTH CARE PROVIDER SIGNATURE REQUIRED:

Health Care Provider's Signature _____ DATE _____

PRINT NAME _____

ADDRESS _____

PHONE# _____ FAX# _____

Required ONLY if answers to TB Screening Questions #1 and/or # 2 were "YES"

TUBERCULOSIS TESTING

NAME: _____

DOB: _____

***Categories of high risk students include those who have arrived within the past 5 years from countries where TB is endemic.**

It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB testing only if they have arrived from countries EXCEPT those on the following list:

Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia or New Zealand.

Other categories of high risk students include those with HIV infection, who inject drugs, who have resided in, volunteered or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g.Prednisone 15 mg/d for 1 month) or other immunosuppressive disorders.

1. Tuberculin Skin Test (PPD or Mantoux only – Required within 6 months of enrollment if indicated by questions 1 and/or 2).

Date Placed: ____/____/____

Date Read: ____/____/____

Result: _____ (Record actual mm of induration)

Interpretation (based on mm of induration as well as risk factors): Positive _____ Negative _____

2. Chest x-ray (required within 6 months of enrollment if TB skin test is positive):

Date of x-ray: ____/____/____

Result: Normal _____ Abnormal _____

3. Preventive or Therapeutic Tuberculosis Treatment prescribed: _____

HEALTH CARE PROVIDER SIGNATURE REQUIRED:

Health Care Provider's Signature _____ DATE _____

PRINT NAME _____

ADDRESS _____

PHONE# _____ FAX# _____