SIENA COLLEGE HEALTH SERVICES
FAX NUMBER (518) 783-2961

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

SIENA COLLEGE HEALTH RECORD

Please complete and review the information with your health care provider prior to your physical exam on page 2.

____ /______/________________________________

LAST NAME (PRINT) FIRST NAME MIDDLE DATE OF BIRTH CELL PHONE#

FAMILY HISTORY					Have any of your relatives had any of the following?			
Age	State of Health	Occupation	Age at Death	Cause of Death		YES	NO	Relationship
Father					Tuberculosis			
Mother					Diabetes			
					Kidney Disease			
Brothers					Heart Disease			
					Arthritis			
					Stomach Disease			
Sisters					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: ____
____

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

REPORT OF PHYSICAL EXAM

NAME:____Date of Birth:__________________________

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	

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 3, Tuberculosis Testing.

2. Is the student a member of a high-risk group (See criteria on Page 3) _____ 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 3

HEALTH CARE PROVIDER SIGNATURE REQUIRED:

Health Care Provider's Signature____DATE__________________________

PRINT NAME ____

ADDRESS____

____

PHONE#____ FAX#_______________________________________

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

TUBERCULOSIS TESTING STUDENT NAME:___________________________Date Of Birth:_____________

Categories of high risk students include those who have arrived within the past 5 years from countries listed below with a high incidence of active TB disease:

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Eswatini
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran (Islamic Republic of)
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Tajikistan
Thailand
Timor-Leste
Togo
Tokelau
Trinidad and Tobago
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2018. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.

Required within 6 months of enrollment if indicated by YES to questions 1 and/or 2)

1. **Tuberculin Skin Test (TST)**

Date Placed: ______/______/______ Date Read: ______/______/______

Result: __________ **(Record actual mm of induration)**

Interpretation (based on mm of induration as well as risk factors): negative _____ positive___

OR

2. **Interferon Gamma Release Assay (IGRA)**

Date Obtained: ____/____/____ (specify method) QFT -GIT T-Spot other_____

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

3. Chest X-Ray (**Required if TST or IGRA is positive**)

Date of x-ray: ______/______/____ Result: Normal _____ Abnormal____

HEALTH CARE PROVIDER SIGNATURE REQUIRED:

Health Care Provider's Signature____DATE______________________________

PRINT NAME ____

ADDRESS____

____

PHONE#____ FAX#____