PHYSICAL EXAMINATION FORM

Health Services Office

Loew Hall Rm. 101
2155 University Avenue
Bronx, NY 10453* Tel.718.289.5858 *
Fax.718.289.6074 * Alternate Fax.718.289.6347

Last Name_____FirstName_____Middle Initial ____
Please Print

Last 4 Digits of SS# ___ ___ ___ ___ Date of Birth ____ /___ /____ Date of Admission _____
Month Day Year

Sex: M___ F___ In Case of Emergency Notify _____ Telephone_____

PERSONAL MEDICAL HISTORY: If your response to any of the following is **YES**, please provide additional details in the space provided.

YES	NO	
		1. Has there been any significant medical illness, injury, weight loss in the past 12 months
		2. Are you taking any medication? If yes, please list.
		3. Are you under a physician's care for containing medical problems?
		4. Have you ever been an in-patient in a hospital?
		5. Have you ever had an accident causing disabling injury?
		6. Have you ever had a fractured bone?
		7. Have you ever had a surgical operation?
		8. Any history of a concussion, blackout, fainting, convulsion, recurrent dizzy spells, heat exhaustion / heart stroke?
		9. Do you wear eyeglasses, contact lenses, dentures or a hearing aid?
		10. Do you have any allergies to medications, foods, or the environment?
		11. Are you missing any organs or other body parts?
		12. Do you have a history of high blood pressure, heart disease, irregular heart rate, palpitations, diabetes, thyroid condition, liver, or kidney problems?
		13. Any history of sudden death in your family (under age 50)?
		14. Have you ever failed a physical examination for military service, employment, insurance or athletic competition?

LIFE STYLE QUESTIONS (TO BE ANSWERED BY THE STUDENT)	YES	NO
Do you smoke?		
Do you exercise regularly?		
Do you drink alcohol or take medication to relieve stress?		
Do you have a problem with your weight?		
Do you go for routine medical/dental checkups?		
Have you ever gone for cancer screening?		
Is your immediate family in good health?		
Have you or a member of your family ever been a victim of a violent crime?		
Have you ever used the emergency room for routine medical problems?		

Specify Type of Health Insurance Private Insurance____ Medicaid____ None____

Bronx Community College has a contract with Morris Heights Health Care Center located at 85 West Burnside Avenue, Bronx, New York 10453 whereby registered students WITHOUT insurance have access to medical services offered at their facilities for a $10.00 co-payment. For an Appointment call (718) 483-1234. A physical exam is not necessary for registration.

ALL INFORMATION ON THIS PHYSICAL EXAMINATION FORM IS CONFIDENTIAL AND CANNOT BE RELEASED WITHOUT A STUDENT'S WRITTEN CONSENT.

The preceding information is complete and correct to the best of my knowledge. I also authorize the release of this information the results of this examination to the Bronx Community College Department of Health and Physical Education.

_____ _____
Signature of Student Date

PHYSICAL EXAMINATION FORM

Student please print name clearly below

Last: **First:** **DOB: / /**

TO BE COMPLETED BY PHYSICIAN

Height _____/_____ Vision: O.D._____O.S._____
Weight_____lbs. Blood Pressure:_____mmHG

PPD Date:_____Result_____
Chest X-Ray Date:_____ Result_____
(if PPD is Positive)

LAB WORK: Hct:_____
Urinalysis: Glucose_____Protein_____

RECOMMENDED FOR STUDENTS OVER 40: EKG_____ Chemistry_____

SIGNIFICANT MEDICAL HISTORY _____
_____

	YES	NO	DESCRIBE
1. Head, Ear, Nose or Throat			
2. Respiratory			
3. Cardiovascular			
4. Gastrointestinal			
5. Hernia			
6. Eyes			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Allergies			

Depression Screening **Done** ☐ **Not Done** ☐ **COMMENTS**_____

Do you have any recommendation regarding the care of this student? Yes ☐ No ☐

If yes, describe briefly_____

Is the student now under treatment for any medical or emotional condition? Yes ☐ No ☐
If yes, describe briefly_____

RECOMMENDATION for **Health & Physical Education class**: Full Activity ☐ Modified Activity ☐ No Activity ☐
Restrictions/Precautions: Explain_____

RECOMMENDATION to **Participate in Competitive Athletics**: Full Activity Yes ☐ No ☐
Restrictions: Explain_____

Physician's Signature_____

Address_____

Telephone No._____

CLINIC STAMP REQUIRED BELOW

Date_____

Revised on 08/21/12