

## NYMC Health Services- *Medical History and Physical Exam*

Last Name/ First Name: \_\_\_\_\_ Touro ID: \_\_\_\_\_

**Part I: Student section: ONLY return form after BOTH student & physician section are completed.**

General Information				
Date of Birth	Sex (M/F)	Email		
Local Physical Address		City	State	Zip
Cell#		Home#		
Physician's Name				
Physician's Phone#		City	State	
Name of Health Insurance Company				
Policy ID#		Policy Group#	Prescription #	
Name of Health Insurance Policy Holder		Policy Holder Date of Birth:	Policy Holder Relationship to Student	
<input type="checkbox"/> Check here if you are the Policy Holder				
Name of Emergency Contact			Relationship	
Home phone #		Cell phone #	Work phone #	

Medications:		
Are you currently taking any medications?	<input type="checkbox"/> No	<input type="checkbox"/> Yes please specify
Do you have allergies to medications, food other?	<input type="checkbox"/> No	<input type="checkbox"/> Yes please specify allergy and reaction

Medical History		
Have you had surgery?	<input type="checkbox"/> No	<input type="checkbox"/> Yes – Specify procedure(s) and year
Have you been hospitalized?	<input type="checkbox"/> No	<input type="checkbox"/> Yes – Specify reason(s) for hospitalization and year
Past and current medical conditions- Check None or list – For current conditions indicate if you need assistance finding a provider		

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**NYMC Health Services helps connect students in need of ongoing care.** Please call our office (914) 594-4234 for assistance. For students infected with HIV, Hepatitis B or Hepatitis C virus, Health Services will provide you with the policy for students infected with blood borne pathogens.

Current conditions: <input type="checkbox"/> None	Past medical conditions: <input type="checkbox"/> None

NYMC offers No-Cost Mental Health Services with 24/7 Support: [NYMC Student Mental Health & Wellness](#); This form is confidentially reviewed by the Office of Mental Health and Wellness for students with a mental health condition and/or who are receiving related medications.

Have you previously experienced or currently experiencing a <b>mental health condition(s)</b> ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify below:
<input type="checkbox"/> Anxiety <input type="checkbox"/> ADHD <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Depression <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Obsessive Compulsive Disorder <input type="checkbox"/> Substance Use/Abuse <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Trauma <input type="checkbox"/> Other (please specify)		
<b>Are you currently followed by a practitioner for the condition(s) you have listed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		

<b>Family History:</b>
List any significant family history: List disease and relationship

<b>Personal and Social History</b>		
Have you lived outside the U.S. for more than one month?	<input type="checkbox"/> No	<input type="checkbox"/> Yes: Specify country, when and where you lived
Have you or do you smoke/ vape?	<input type="checkbox"/> No	<input type="checkbox"/> Yes: Specify amount and duration below
Do you feel that you are habitually using any drugs or alcohol?	<input type="checkbox"/> No	<input type="checkbox"/> Yes: Please specify below

<b>Review of Systems:</b> Please indicate by checking the appropriate box, or list the condition in the system; Specify if other	
General: <input type="checkbox"/> weight gain, <input type="checkbox"/> weight loss	GI: <input type="checkbox"/> constipation, <input type="checkbox"/> diarrhea, <input type="checkbox"/> rectal bleeding, <input type="checkbox"/> stomach pains, <input type="checkbox"/> hepatitis, <input type="checkbox"/> other
Skin: <input type="checkbox"/> rashes, <input type="checkbox"/> other	GU: <input type="checkbox"/> blood in urine, <input type="checkbox"/> testicular lumps, <input type="checkbox"/> other
HEENT: <input type="checkbox"/> head injury, <input type="checkbox"/> hearing disorder	GYN: <input type="checkbox"/> abnormal menses, <input type="checkbox"/> other
Neck: <input type="checkbox"/> swollen glands, <input type="checkbox"/> thyroid disorder	Blood or Immune disorder - <input type="checkbox"/> If yes, please specify:
Lungs: <input type="checkbox"/> wheezing, <input type="checkbox"/> infections, <input type="checkbox"/> other	Neurologic: <input type="checkbox"/> headaches, <input type="checkbox"/> seizures, <input type="checkbox"/> vision disorder
Cardiac: <input type="checkbox"/> high/low blood pressure, <input type="checkbox"/> cardiac disorder	Skeletal: <input type="checkbox"/> Joint pain, <input type="checkbox"/> back problems, <input type="checkbox"/> other:
Endocrine: <input type="checkbox"/> diabetes, <input type="checkbox"/> thyroid disorder, <input type="checkbox"/> other	Psychiatric: <input type="checkbox"/> anxiety, <input type="checkbox"/> sleep issues, <input type="checkbox"/> mood swings, <input type="checkbox"/> depression

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**Part II: Physician Section:  
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Student medical history, medications and review of systems reviewed check here

**TUBERCULOSIS (TB) RISK ASSESSMENT as per NYSDOH guidelines**

1. Has the patient ever had a positive tuberculin skin test (TST) or IGRA (QuantiFERON) or evidence of TB?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Specify below:
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Test Date:	For TST, provide mm: For IGRA, Lab report of prior test is provided: Check here: <input type="checkbox"/>
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CXR after positive TST or IGRA:	CXR Date:	CXR report attached to this form: Check here: <input type="checkbox"/>
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2. Has the patient ever been treated for latent TB or active TB?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Specify:
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Medications	Dates Medication Received
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3. **TB Symptom Survey for Persons with History of Latent or Active TB:** Check here if *not* applicable

Specify details below if the patient has any of the following symptoms: Persistent cough > 2 weeks; Cough producing phlegm or blood; Enlarged lymph nodes in the neck or upper chest; Unexplained fever or night sweats or chills for longer than 2 weeks; Unexplained weight loss of > = 5 lbs.

**TB Screening for Students with NO History of Latent/Active TB**  
Can be done by IGRA (QuantiFERON) OR TST performed at the time of physical exam.

**For TST performed at visit:** Lot # \_\_\_\_\_ TST Lot # Expiration Date \_\_\_\_\_

Date TST placed \_\_/\_\_/\_\_ TST Result (positive / negative) and mm: \_\_\_\_\_ mm

Date TST read \_\_/\_\_/\_\_ **If newly positive TST:** Date of CXR ordered \_\_/\_\_/\_\_

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PHYSICAL EXAMINATION					
Date of Exam	Height	Weight	Temp	Pulse	BP
General:			Lymphatic:		
Skin:			Abdomen:		
HEENT & Neck:			Extremities:		
Lungs:			Musculoskeletal:		
Heart:			Neurologic:		
Breasts/ Testicles:			Other Findings:		

HEALTH PROVIDER ASSESSMENT
<p><b>Please check one after you have reviewed the student's medical information.</b></p> <p><input type="checkbox"/> The student has <u>no medical limitation</u> for ongoing health professional and clinical studies.</p> <p><input type="checkbox"/> The student has the following health condition(s) for which continuation of care is required. Please specify as to whether this poses a limitation or restriction for clinical activities.</p>

Provider Name (Please print) \_\_\_\_\_ State and License# \_\_\_\_\_

NPI # \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone Number \_\_\_\_\_