

Saint Joseph's College of Maine Health and Wellness Center

278 Whites Bridge Road, Standish, ME 04084-5263

Tel (207) 893-6634 / Fax (207) 893-7865

PLEASE PRINT **PERSONAL INFORMATION**

LAST NAME	FIRST NAME	MIDDLE INITIAL
DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX MALE [] FEMALE []

FAMILY MEDICAL HISTORY

	Age	Current Health	Cause of Death (if applicable)		Any family history of:	Yes	No
Father	_____	_____	_____		Diabetes	_____	_____
Mother	_____	_____	_____		Heart Disease	_____	_____
Sibling	_____	_____	_____		Cancer	_____	_____
Sibling	_____	_____	_____		Drug Abuse	_____	_____
Sibling	_____	_____	_____		If yes, please explain	_____	

PERSONAL MEDICAL HISTORY

	Y	N		Y	N
Eating Disorder			Rubella		
Alcohol/Drug Abuse			Hepatitis B Disease		
Anxiety/Depression/Mental Illness/ADHD			High Blood Pressure		
Asthma			HIV/AIDS		
Cancer			Measles		
Cardiac Condition/Heart Murmur			Mononucleosis		
Chicken Pox			Mumps		
Convulsions/Seizure Disorder			Rheumatic Fever		
Dental Problems			Sickle Cell Anemia		
Diabetes			Thyroid Disorder		
Kidney Problems			Tuberculosis		
Gastrointestinal Problems			Other		
Head injury with loss of consciousness					

ALLERGIES		Y	N
Food (List Food)	Life Threatening?		
Drug (List Drug)	Life Threatening?		
Insect (List Insect)	Life Threatening?		
Other (List)	Life Threatening?		

PRIOR HOSPITALIZATIONS/SURGERY	DATE	HEALTH BEHAVIORS
Previous Surgery/Hospitalization/Injury? Explain		Do you smoke? Y N How much? _____ Number of years? _____
Physical Impairment? Explain		Do you drink alcohol? Y N How much? _____ How often? _____
Emotional Problems Requiring Treatment? Explain		Do you drink caffeine? Y N How much? _____
Current Medications? List		Do you engage in recreational drug use? Y N
		Do you engage in IV drug use? Y N
		Regular exercise? Y N
		Use seat belts? Y N
		Use bike helmets? Y N
		Take vitamins/supplements? Y N

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PLEASE PRINT **REPORT OF HEALTH EVALUATION**

To the Physician: This student has been admitted, please review the student history and complete this physician's form commenting on all positive or abnormal findings. All items are required.

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF EXAM
DATE OF BIRTH		SOCIAL SECURITY NUMBER	

Height _____ Weight _____ BMI _____ Blood Pressure: Systolic _____ Diastolic _____ Pulse: ___Regular ___Irregular	Visual Acuity: ___Normal ___Abnormal Uncorrected: RT 20/ LT 20/ Corrected: RT 20/ LT 20/ Does the student wear glasses / contact lenses? ___Yes ___No Is color vision normal? ___Yes ___No
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Physical Examination	Normal	Abnormal <small>Please explain</small>		Normal	Abnormal <small>Please explain</small>
Skin, hair and nails			Extremities/Musculoskeletal		
Head, eyes, ears, nose, sinuses			Genitalia/Hernia (male only)		
Mouth, throat, dentition, neck			Neurologic		
Heart			Psychiatric		
Lungs			Lymph nodes		
Abdomen			Other:		

Recommendations for physical activity: ___ Limited ___ Unlimited
 Explain: _____

Is there loss or seriously impaired function of any organ? ___Yes ___No
 Explain: _____

Is student now under treatment for any physical or emotional problems? ___Yes ___No
 Explain: _____

PHYSICIAN'S SIGNATURE _____

PHYSICIAN'S NAME (printed) _____

Address _____

Date _____