1912 SAINT JOSEPH'S COLLEGE

HEALTH AND WELLNESS CENTER

278 Whites Bridge Road, Standish, ME 04084-5236
Tel 207-893-6634 • Fax 207-893-7865 • healthcenter@sjcme.edu

PLEASE PRINT

PATIENT HISTORY

LAST NAME | FIRST NAME | MIDDLE INITIAL

DATE OF BIRTH | STUDENT ID # | SEX MALE [ ] FEMALE [ ]

FAMILY MEDICAL HISTORY

	Age	Current Health	Cause of Death (if applicable)
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling	_____	_____	_____
Sibling	_____	_____	_____
Sibling	_____	_____	_____

Any family history of:	Yes	No
Diabetes	_____	_____
Heart Disease	_____	_____
Cancer	_____	_____
Drug Abuse	_____	_____

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**

Previous Surgery/Hospitalization/Injury? Explain

Physical Impairment? Explain

Emotional Problems Requiring Treatment? Explain

Current Medications? List

HEALTH BEHAVIORS

Do you smoke? **Y N** How much?_____ Number of years?_____
Do you drink alcohol? **Y N** How much?_____ How often?_____
Do you drink caffeine? **Y N** How much?_____
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 **PHYSICAL 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	STUDENT ID #

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

Physical Examination	Normal	Abnormal Please explain		Normal	Abnormal Please explain
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 _____

JUN2015