

**REPORT OF MEDICAL HISTORY**

**For Clinical Experiences in Health Sciences**

• Please complete this form before going to your physician for an examination.

• Information you provide is used solely as an aid to providing health care, if necessary, while you are a student.

• Information is strictly for the use of Clinical Education and is not released to anyone without your knowledge and consent.

Last Name (Print) First Name Middle Gender

Home Address (Number and Street) City or Town State Zip Code

Social Security Number Date of Birth

Name, Relationship of Parent or Guardian Home Phone

Address of Parent or Guardian Business Phone

In Emergency Notify: Name Address Phone

**FAMILY HISTORY Have any of your relatives ever had any of the following?**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Age** | **State**  **of Health** | **Occupation** | **Age at**  **Death** | **Cause of**  **Death** |  | **Yes** | **No** | **Relationship** |
| Father |  |  |  |  |  | Tuberculosis |  |  |  |
| Mother |  |  |  |  |  | Diabetes |  |  |  |
| Brothers |  |  |  |  |  | Kidney Failure |  |  |  |
|  |  |  |  |  |  | Heart Disease |  |  |  |
|  |  |  |  |  |  | Arthritis |  |  |  |
|  |  |  |  |  |  | Stomach Disease |  |  |  |
| Sisters |  |  |  |  |  | Asthma, Hay Fever |  |  |  |
|  |  |  |  |  |  | Epilepsy, Convulsion |  |  |  |
|  |  |  |  |  |  | Cancer |  |  |  |
|  |  |  |  |  |  | High Blood Pressure |  |  |  |

**PERSONAL HISTORY Please answer all questions.**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Have you had** | **Yes** | **No** |  | **Yes** | **No** |  | **Yes** | **No** |  | **Yes** | **No** |
| Mononucleosis |  |  | Acne |  |  | Anemia |  |  | Bleeding Disorders |  |  |
| Hepatitis |  |  | Insomnia |  |  | Palpitations (Heart) |  |  | Recurrent Diarrhea |  |  |
| Chicken Pox |  |  | Frequent Anxiety |  |  | High Blood Pressure |  |  | Recurrent Constipation |  |  |
| Gum or Tooth Trouble |  |  | Frequent Depression |  |  | Low Blood Pressure |  |  | Malaria |  |  |
| Sinusitis |  |  | Worry or Nervousness |  |  | Rheumatic Fever |  |  | Hernia |  |  |
| Eye Problem |  |  | Recurrent Nervousness |  |  | Heart Murmur |  |  | Sexually Transmitted Diseases |  |  |
| Ear Problem |  |  | Hay Fever |  |  | Tumor, Cancer, Cyst |  |  | Herpes |  |  |
| Nose Problem |  |  | Bronchitis |  |  | Jaundice |  |  | Thyroid Problem |  |  |
| Throat Problem |  |  | Pneumonia |  |  | Gallbladder Trouble |  |  | **Females Only** |  |  |
| Diabetes |  |  | Tuberculosis |  |  | Intestinal Trouble |  |  | Irregular Periods |  |  |
| Seizures |  |  | Shortness of Breath |  |  | Stomach Trouble |  |  | Severe Cramps |  |  |
| Eczema |  |  | Asthma |  |  | Recent Weight Gain |  |  | Excessive Flow |  |  |
| Head injury with  Unconsciousness |  |  | Chest Pain |  |  | Recent Weight Loss |  |  | Abnormal PAP Smear |  |  |
| Cystic Fibrosis |  |  | Chronic Cough |  |  | Dizziness or Fainting |  |  | Pregnancy |  |  |
| Neck Injury |  |  | Back Problems |  |  | Weakness, Paralysis |  |  | Cystic Breasts |  |  |
| Do you drink alcohol? |  |  | Diseases/Injury of Joints |  |  | Bladder infection |  |  | **Males Only** |  |  |
| Do you smoke? |  |  | Hearing Difficulty |  |  | Kidney Infection |  |  | Prostate Problems |  |  |
| Do you want to quit smoking? |  |  |  |  |  |  |  |  | Lump or Mass in Testicle |  |  |

**ALLERGIES (Please list):**

**PHYSICIAN’S REPORT OF HEALTH EVALUATION**

**For Clinical Experiences in Health Sciences**

**TO THE EXAMINING PHYSICIAN:** Please review the student’s history and complete the physician’s form. Please comment on all positive answers. All items marked with **an asterisk (\*) are “REQUIRED”** and must be completed or the form will be returned for completion.

Last Name (Print) First Name Middle Gender

B/P

P R

Height (inches)

Weight (lbs.)

Are there abnormalities of the following systems? Describe fully. Use additional sheet if needed.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  | **Yes** |  | **No** |  | **Description (if needed)** |
| 1. | Head, ears, 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. | Hematological/Immunological |  |  |  |  |  |  |

13. Is the patient now under treatment for any medical or psychological condition? \_\_ Yes \_\_ No

If yes, explain and list medications:

14. Is there loss or seriously impaired function of any paired organ? \_\_Yes \_\_ No

If yes, explain

**\*15. I certify** that I have reviewed the medical history and examined the above student for participation in clinical education at LVC in the Health Sciences.

|  |  |  |  |
| --- | --- | --- | --- |
| I recommend: | |  | Comments (include estimated time frames for any restrictions): |
|  | Clearance with no limitation |  |  |
|  | Clearance pending further evaluation or testing |  |  |
|  | Referral to other healthcare professional prior to clearance |  |  |
|  | Clearance with limitations |  |  |
|  | Disqualified from clinical experience |  |  |

**Healthcare Provider Information** (Physician, CRNP, PA-C, etc.)

|  |  |
| --- | --- |
| Name | Phone #/Fax # |
| Address |  |
| Signature | Date |

Office Stamp:

**PREADMISSION IMMUNIZATION POLICY**

**For Clinical Experiences in Health Sciences**

All incoming freshmen, transfer students and foreign exchange students are required to have the following immunizations completed according to these requirements before matriculating at Lebanon Valley College.

Last Name (Print) First Name Middle Gender

NOTE: IMMUNIZATIONS MARKED WITH AN ASTERISK (\*) ARE MANDATORY; INCOMPLETE OR INCORRECT IMMUNIZATION REPORTS WILL BE RETURNED TO YOU.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **VACCINE** | **DATE** |  | **VACCINATION** | **DATE** |
| **DTP Series** | \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ |  | **Hepatitis B**  Series of 3  (*Strongly Recommended)* | \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_ |
| **\*TDAP/Adacel/Boostrix** (Circle)  (Booster in last 10 years) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | **\*Influenza** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **\*OPV (Polio) Series**  Date, series, and booster completed  Or titer \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ |  |  |  |
| **\*MMR**  2 doses or immune titer \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ |  | \*TUBERCULOSIS: REQUIRED FOR ALL STUDENTS | |
| **\*Varicella Disease**  **OR**  **\*Varivax vaccine**  Per CDC guidelines: 2 vaccines | \_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ |  | Tuberculosis Testing (PPD) within the last 12 months\* required regardless of prior BCG inoculation  **Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Result:**  \_\_Neg \_\_Pos  Induration mm | **If positive:**  **Chest x-ray required**  **Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Results: (Circle)**  Normal Abnormal  **Dates of INH Therapy**  **\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_** |
| **Meningococcal (Menactra) (A/C/Y/W-135)**  **\*Required of all residential students**  (Per CDC guidelines: if primary dose administered before age 16, then a booster is required) | \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ |  |

**Healthcare Provider Information** (Physician, CRNP, PA-C, etc.)

|  |  |
| --- | --- |
| Name | Phone #/Fax # |
| Address |  |
| Signature | Date |

Office Stamp:

**Please make a copy of this entire form (for your records) before submitting the original to the Program.**

**INSURANCE INFORMATION**

**For Clinical Experiences in Health Sciences**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Insured | |  | | | | | | |
|  | |  | | | | | | |
| Name of Insurance Company | | | |  | | | | |
|  | | | |  | | | | |
| Insurance Company Address | | | |  | | | | |
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|  | | | |  | | | | |
| Insurance Company Telephone | | | | | ( ) | | | |
|  | | | | |  | | | |
| Group Number |  | | | | | | ID/Certificate Number |  |
|  |  | | | | | |  |  |
| Name of Primary Care Physician | | | | | |  | | |
|  | | | | | |  | | |
| Physician Telephone | | | ( ) | | | | | |