

# Optional Health History Form

*This Form Requires a Physician Evaluation for Completion*

## Attention Parent and Student

It is *recommended* that all students have a complete medical evaluation performed prior to attendance at UAlbany. **(This is especially important for any students with medical/psychiatric conditions requiring ongoing care, student athletes and students born or arriving from outside the U.S.).** Students must fill out and submit the **Required Immunization and Health Information** form, even if the **Health History Form** is submitted.

- A complete medical evaluation allows your primary care physician to determine any special needs you may require once you arrive on campus.
- Completion of this form provides Medical Personnel at the Student Health Center with valuable information which improves the care they provide.
- Completion of this form clarifies a student-athlete's ability to participate in intercollegiate athletics. **All athletes trying out for an intercollegiate sport are required to obtain clearance to participate in athletics from their primary care physician prior to tryouts.**
- Completion of this form enables anyone born outside the U.S. to clarify any health issues which may impact their participation with campus life.

### Please return to:

University Health Center

University at Albany, Suite 200, 400 Patroon Creek, Albany, NY 12206

Fax: (518) 442-5444

[http://www.albany.edu/health\\_center](http://www.albany.edu/health_center)

Student: \_\_\_\_\_ Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First M.I. Month Day Year

Cell or Preferred Phone Number: ( ) \_\_\_\_\_ UAlbany ID # \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Country

Emergency Contact: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Are you entering the University as:  Undergrad-Freshman  Undergrad-Transfer  Graduate Student

Male  Female  Transgender

Have you attended the University at Albany in the past?  No  Yes If yes, last year attended: \_\_\_\_\_

Previous Name: \_\_\_\_\_  
If you attended University at Albany under a different name

# Medical Provider to Complete

Patient Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Month

Day

Year

## I. Immunization Records

Please provide a copy of all immunizations received by the student.

## II. History and Physical

Medical History:

Current medical conditions for which the student is being treated:

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Medical conditions for which the student has been treated for in the past but are currently inactive:

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History of lab confirmed mononucleosis?  Yes  No

Psychiatric conditions which the student has ever been treated for (please indicate if currently under treatment or resolved):

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Surgeries:

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Medications (including OTC's & supplements):

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Medication Allergies (include reaction):

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Environmental & Food Allergies:

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# Physical Examination

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month                      Day                      Year

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ BP: \_\_\_\_\_ Pulse: \_\_\_\_\_

Vision: Right 20/ \_\_\_\_\_ Corr. To 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_ Corr. To 20/ \_\_\_\_\_ Corrective Vision (Y/N) \_\_\_\_\_

Item/Area Evaluated	Normal	Not Examined	Abnormal	If Abnormalities Are Noted, Please Describe
Nose & Sinuses				
Mouth & Throat				
Teeth & Gingiva				
Ears				
Eyes				
Neck				
Lungs				
Heart				
Vascular				
Abdomen				
Ano-rectal				
Genitalia				
Upper Extremities				
Lower Extremities				
Spine				
Neurologic				
Psychiatric				

Lab tests at discretion of provider  
 (no screening labwork is required by UAlbany) \_\_\_\_\_

Participation in athletics:     Unlimited     Limited  
 (explain) \_\_\_\_\_

If follow-up recommended, please request student to make appointment at the student health center (518) 442-5229 or the examining provider may contact the Medical Director at (518) 442-5461.

**I certify that the above information is correct to the best of my knowledge:**

**MD/DO/NP/PA**

\_\_\_\_\_  
Physician/Provider Name (printed) Physician/Provider Signature

Address: \_\_\_\_\_

Phone Number: (         )                      Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month                      Day                      Year

Fax: (         )                      Email: \_\_\_\_\_

# TB (Tuberculosis) Evaluation

Patient Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Month

Day

Year

- A.** If the patient was previously diagnosed with TB Infection (Active or Latent) and has completed treatment with an anti-TB drug, please specify which drug and dose. Include the start and end dates of treatment.

Drug/dose: \_\_\_\_\_

Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_

Provide any medical documentation available to support this information.

## **B. Risk Factor Evaluation:**

(Domestic Students Only). Note: International students will be evaluated on campus during Orientation week.

Please complete the following checklist:

**YES**      **NO**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Signs or symptoms of active TB? (Cough over two weeks, fever, weight loss?)</b>   |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Known HIV infection?</b>  |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Any close contact with a TB infected individual?</b>  |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>History of IV drug use?</b>   |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Any history of resident or employee of any of the following?:</b><br>Prisons/jails, nursing homes/long term care facility for the elderly, health care facility, homeless shelter   |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Chronic medical condition?</b><br>Diabetes, blood diseases, kidney disease, cancer, malnutrition, abdominal surgery with intestinal resection, prolonged steroid therapy (one month or longer), any immunosuppressive therapy, lung disease (other than asthma) |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>*Any history of residence (over 4 weeks) or birth in a TB endemic area?</b>   |

**\*All countries in the African, Eastern Mediterranean, & Southeast Asian Regions are TB endemic**

**NOTE:** Any country **NOT** on the list below is considered a TB endemic area:

**AMERICAN REGION:** USA, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Costa Rica, Cuba, Jamaica, Saint Kitts and Nevis, Puerto Rico, Saint Lucia, Trinidad, Virgin Islands

**EUROPEAN:** Albania, Belgium, Cyprus, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Slovakia, Slovenia, Sweden, Switzerland, United Kingdom

**WESTERN PACIFIC:** American Samoa, Australia, New Zealand

**MIDDLE EAST:** Israel, Jordan, Lebanon, United Arab Emirates

- If there are NO risk factors, a PPD is not required for admission to UAlbany.
- If ANY risk factors are identified and the patient has not been treated for TB Infection, a PPD must be performed within 6 months prior to arrival on campus.
- ALL positive PPD's require that a chest x-ray be performed and a report copy attached.
- If the patient has history of a positive PPD please document reaction size and date performed – do not repeat the PPD.

**Any PPD or Chest X-Ray results must be performed within the United States and within 6 months prior to arrival on campus to be acceptable by UAlbany.**

**NOTE:** Prior BCG vaccination does NOT preclude placement of a PPD if it is otherwise indicated

PPD results (only if indicated by risk factors) \_\_\_\_\_ mm.

Date Placed: \_\_\_\_\_

Date Read: \_\_\_\_\_

Read by: \_\_\_\_\_

Signature

Printed Name

5mm or greater is **positive** if HIV infection, symptoms of TB or recent exposure to TB.

10mm or greater is **positive** if any risk factors are present.

**I certify that the above information is correct to the best of my knowledge:**

**MD/DO/ NP/PA**

Physician/Provider Name (printed)

Physician/Provider Signature

Date: \_\_\_\_\_

Month

Day

Year