



**Rochester Institute of Technology**  
**Student Health Center**  
**117 Lomb Memorial Drive**  
**Rochester, New York 14623-5608**  
**585-475-2255 (v) 475-5515 (tty) Fax: 585-475-7788**

**Health  
History  
Form**

Accredited by: Accreditation Association for Ambulatory Health Care, Inc.

This **confidential** information is for the use of the Student Health Center only. Information will not be released to anyone without your knowledge and written consent.

**Please print in black or blue ink**

You are responsible for completing and returning these forms in their entirety to the Student Health Center. Please maintain a copy for your records

**TO BE FILLED OUT BY THE STUDENT**

			<b>Sex</b>
<b>Name:</b>	<b>Last</b>	<b>First</b>	<b>Middle</b>

<b>Home Address # and Street</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>	<b>Country</b>
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<b>Home Telephone Number</b>	<b>Date of Birth</b>
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<b>Personal Physician</b>	<b>Address</b>	<b>Telephone Number</b>
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<b>Medical Insurance Company</b>	<b>Address</b>	<b>Telephone Number</b>
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<b>Policy Number</b>	<b>Subscriber Name</b>
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**Person to be notified in case of emergency:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**AUTHORIZATION FOR TREATMENT**

In submitting this Health History Form, I attest that the information is complete and accurate. I understand that information may be shared with Athletics staff and/or Counseling Center staff as/if needed, in order to facilitate collaboration among campus services **for my comprehensive care.**

I authorize Rochester Institute of Technology Student Health Center to provide medical treatment and services as they deem appropriate. I understand that my medical records are confidential and maintained separately from my academic records. To have my records shared with others requires my written permission **except in the event of a life-threatening and/or serious illness or injury of which the Student Health Center is aware, when parents or guardian may be notified at the discretion of the professional staff.**

Student signature	Date
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Parent or guardian signature	Date (for students under 18 years of age)
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# Personal Medical History

Please read each item and check all that apply

	Past History	Current History	Never		Past History	Current History	Never
<b>1. Infectious Diseases</b>				<b>6. Musculoskeletal</b>			
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone or joint deformity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Broken Bone(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>2. Eyes, Ears, Nose and Throat</b>				<b>7. Hematologic or Oncologic</b>			
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia or lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses or contacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other visual problems: Describe: _____				Cancer: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. Cardiopulmonary</b>				<b>8. Neuropsychiatric</b>			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis/pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal Thoughts or Acts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction/Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy (seizures)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serious Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. Gastroenteric</b>				<b>9. Metabolic</b>			
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reflux/GERD/Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Gall Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>10. Birth Defects</b>			
Hepatitis – Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____			
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Irritable/spastic bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>11. Sexual Health</b>			
Regular Laxative Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Positive HIV Antibody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal PAP Smear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>5. Urinary</b>				Breast Lump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystitis/bladder infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DES exposure (maternal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Infection/Pyelonephritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Testicular Lump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stone(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Undescended or absent testicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Hydrocele or varicocele	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Other Significant Medical Problems:** \_\_\_\_\_

**Hospitalization/Reason/Dates:** \_\_\_\_\_

**Surgeries/Reason/Dates:** \_\_\_\_\_

**Personal Medical History, continued**

Drug allergies/type of reactions: \_\_\_\_\_

Medications (including oral contraceptives) taken regularly--include dosage: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Supplements (vitamins, herbs, others): \_\_\_\_\_

Exercise: Type and frequency \_\_\_\_\_

Cigarette/tobacco use: Yes\_\_\_ No\_\_\_      Age started\_\_\_ Avg #/day\_\_\_ Age stopped\_\_\_

Alcohol use:              Yes\_\_\_ No\_\_\_      Average number drinks/week\_\_\_

History of alcohol/drug treatment/hospitalization:      Yes\_\_\_      No\_\_\_

Explain: \_\_\_\_\_  
\_\_\_\_\_

History of eating disorder: Explain: \_\_\_\_\_

History of emotional or mental health problems sufficient to warrant treatment:  
Explain: \_\_\_\_\_  
\_\_\_\_\_

**TO THE STUDENT:** Although not required by RIT, a complete physical examination may be to your benefit. If you have been under treatment for a chronic condition or serious illness, a detailed statement from your physician will help us provide informed continuity of care. Thank you.

**TO THE PHYSICIAN:**  
Please review the information provided on this form and answer the following questions. Where appropriate, we ask that you send a clinical report to assist in responding to your recommendations. Thank you.

**Vital Signs:**    Date:\_\_\_/\_\_\_/\_\_\_    BP \_\_\_\_\_/\_\_\_\_\_    Height:\_\_\_\_\_    Weight \_\_\_\_\_

Is this individual on medication? If yes, please list by name and include dosage: \_\_\_\_\_  
\_\_\_\_\_

Does this individual have drug allergies? If yes, please list by name and type of reaction: \_\_\_\_\_  
\_\_\_\_\_

If this individual is under care for a chronic condition or serious illness, please explain and list recommendations for continuing care: \_\_\_\_\_  
\_\_\_\_\_

Name and Signature of Physician: \_\_\_\_\_ **x** \_\_\_\_\_  
Address: \_\_\_\_\_

Phone Number: (    ) \_\_\_\_\_    Fax Number: (    ) \_\_\_\_\_    Date: \_\_\_\_\_

**IMMUNIZATION RECORD: PLEASE LIST EXACT DATES (MONTH/DAY/YEAR) FOR ALL IMMUNIZATIONS**

Name: \_\_\_\_\_  
Last First Middle Initial

Student ID Number: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

New York State law mandates vaccinations with verification for measles, mumps and rubella. Failure to comply with the law will prevent your obtaining clearance for registration. Students born before January 1, 1957 are exempt.

Required immunizations, tests and dates sections **MUST** be completed. *Verification is required for each section below by your physician or an appropriate school official. All information must be submitted in English.*

**Measles/Rubeola, Mumps and Rubella: Required proof of TWO MMR vaccinations.** Vaccination #1 on/or after first birthday with vaccination #2 given at least 30 days following vaccination #1. If no vaccination, proof of positive titer for each is necessary.

MMR #1 \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

MMR #2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Measles Titer: Immune? Yes\_\_\_ No\_\_\_ *Laboratory report must be attached.*  
Mumps Titer: Immune? Yes\_\_\_ No\_\_\_ *Laboratory report must be attached.*  
Rubella Titer: Immune? Yes\_\_\_ No\_\_\_ *Laboratory report must be attached.*

**Meningococcal Tetravalent (A, C, Y, W-135 Vaccine: Required for all entering RIT students 26 years of age and younger: (See Page 4)**

Menactra/Conjugate (preferred) \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

OR Menomune/Polysaccharide \_\_\_\_/\_\_\_\_/\_\_\_\_ (given within past 5 years)  
Month Day Year

**Hep B** #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ #3 \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year Month Day Year Month Day Year

**Polio:** Year series completed: \_\_\_\_\_ **DPT:** Year series completed: \_\_\_\_\_

**Tetanus Booster:** Tdap \_\_\_\_/\_\_\_\_/\_\_\_\_ Td (within 10 years) \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year Month Day Year

Tdap (preferred) to replace a single dose of Td for booster immunization.

**Tuberculosis Screening: (see page 4)**  
PPD (Tine not accepted) Mo \_\_\_\_\_ Yr \_\_\_\_\_ Results: \_\_\_\_\_ mm

Chest X-ray (required if PPD positive) Results: \_\_\_\_\_

X \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Physician or School Official Title Date

**This page contains information that needs to be completed by the student.**

## **Meningococcal and Tuberculosis Information Sheet** **Meningococcal Immunization of RIT Students**

Meningococcal meningitis is a rare but dangerous illness that mainly affects children and young adults. College-aged students have a greater potential risk of outbreaks than the general population due to a prevalence of risk factors that are often part of campus life. These risks include residence hall (or other group) living, active and passive smoking, bar patronage, and alcohol consumption. The current vaccine protects against four of the five strains of the disease; these strains account for 70% of cases among college students. Adverse reactions to the vaccine are mild and infrequent. As with other immunizations, vaccination against meningococcal meningitis may not protect 100% of all susceptible individuals. Immunity develops 7 to 10 days following vaccination. **The state of New York requires that colleges and universities provide information about the disease.**

Pre-exposure vaccination greatly reduces a student's risk of disease, and is an **(RIT) Institute requirement** for students:

- 26 years of age or younger who are not pregnant

Other students who should consider the vaccination include:

- Students 26 years of age or **older** (who are not pregnant) with chronic immune deficiency problems and patients without a functional spleen who elect to decrease their risk for disease.
- Students traveling to areas of the world where the disease is known to be endemic.

New York State Public Health Law **requires** that all students enrolled for at least four (4) credit hours per quarter, complete this portion of the Health History Form. **Check box and sign below.**

I have (for students under the age of 18: My child has): read, (or had explained), the information regarding meningococcal meningitis disease. I understand the benefits and risks of the vaccine.

Signed: \_\_\_\_\_ / \_\_\_\_\_  
Signature of Student (Parent/Guardian if under the age of 18) Date of Signature

*Please contact the Student Health Center for cost and availability of meningococcal vaccine.*

## **Tuberculosis Screening of RIT Students**

Recommendation for performing TB (Tuberculosis) screening on university students have changed in the recent past. The ACHA (American College Health Association) and other professional organizations now propose that only **HIGH RISK** individuals be screened. The purpose of screening is to identify persons with TB infection (active TB) or latent TB infection (LTBI). Both forms of TB require treatment.

Screening of high risk individuals should occur within 3 months **PRIOR TO** college entrance.

The Student Health Center at Rochester Institute of Technology recommends screening of the following high risk groups:

- Persons with signs or symptoms of active TB
- Persons with HIV infection
- Persons who have been close contacts of a person with infectious TB
- Persons who inject drugs
- Persons who have resided in, have been employed by, or volunteered in the following high-risk congregate settings: prisons and jails, nursing homes and other long-term facilities for the elderly, hospitals and other health care facilities, residential facilities for patients with acquired immunodeficiency syndrome (AIDS), and homeless shelters
- Persons with medical conditions that place them at high risk: consult your personal health care provider.
- Persons who have lived, within the past 5 years, in countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries

**OTHER THAN** those listed below:

**American Region:** Canada, Jamaica, St. Kitts and Nevis, St. Lucia, USA, Virgin Islands (USA)

**European Region:** Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein,

Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom

**Western Pacific Region:** American Samoa, Australia, New Zealand

**STUDENTS FROM THE ABOVE LISTED COUNTRIES, WHO HAVE NO OTHER KNOWN RISKS, DO NOT NEED TO UNDERGO TB SCREENING.**

*contact the Student Health Center with questions*

*Please*

revised 7/08