

Personal Medical History

Please read each item and check all that apply

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

Meningococcal Tetravalent (A, C, Y, N-135) Vaccine:

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 one box and sign below.**

I have (for students under the age of 18: My child has):

- read, (or have had explained), the information regarding meningococcal meningitis disease (see page 4). I understand the risks of not receiving the vaccine. I am requesting exemption from the RIT requirement for the meningococcal vaccine for the following reason(s): Religion* Medical* Age (list DOB) _____
 Non RIT housing –Please submit local utility bill, lease, local license, etc. to support exemption.*
** Supporting documentation for all reasons must be attached*

- had the meningococcal tetravalent immunization. Menomune Date: _____
 Menactra Date: _____

Signed: _____ / _____
(Student or Parent/Guardian) Date of Signature

New York State law mandates vaccinations with verification, as indicated below, 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.

Month/Day/Year
____/____/____ MMR #1
____/____/____ MMR #2

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.*

Hep B # 1 ____/____/____ #2 ____/____/____ #3 ____/____/____

Polio: Year series completed: _____ **DPT:** Year series completed: _____

Tetanus Booster: **Tdap** ____/____/____ **Td** (within 10 years) ____/____/____

Booster: Tdap (preferred) to replace a single dose of Td for booster immunization at least 2-5 years since last dose of Td, depending on age of patient. (Administer with MCV4 simultaneously if possible).

Tuberculosis Screening: (see page 4)

PPD (Tine not accepted) Mo _____ Yr _____ Results: _____ mm
Chest X-ray (required if PPD positive) Results: Positive _____ Negative _____

X _____ / _____ / _____
Signature of Physician or School Official Title Date

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:

1. 26 years of age or younger who are not pregnant
2. Living in residence halls, shared apartments or other group situations

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.

Requests for exemptions based upon religion, medical issues, age, or housing circumstance **must** be accompanied by supporting documentation.

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 3 months PRIOR TO or after 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.

Please contact the Student Health Center with questions