Mail or Fax All Forms To:
NJIT – Student Health Services
Estelle & Zoom Fleischer Athletic Center
323 Martin Luther King., Newark, NJ 07102
Office #: 973-596-3621 – ***Fax #:*** 973-596-0047

HEALTH HISTORY QUESTIONNAIRE PHYSICAL EXAMINATION

TO THE STUDENT: This information is required that NJIT Student Health Services can provide care based on our particular needs. This form becomes a part of your student health record. It as well as any other health care information obtained while you are at NJIT, are confidential and will not be released to anyone without your written permission. These records must be submitted prior to or the day of registration to Health Services. If your records are not submitted within this time, a ***HOLD*** will be placed on your future registration until you provide us with your records. **Please check the following:** Undergraduate___Graduate____Full-time ___Part-time Student___

FULL TIME STUDENT REQUIREMENTS:
Tuberculosis Test within the past 12 months
of your registration *(test result is needed)*
Measles (*Proof of two doses*) after your 1st birthday
Mumps (*Proof of two doses*) after your 1st birthday
Rubella (*Proof of two doses*) after your 1st birthday
Or a serology test for Mumps, Measles, and Rubella
(a lab report is needed)
Physical Exam, by a physician (*within the past year of your registration*)
Hepatitis B – Proof of 3 doses or lab evidence of immunity

PART-TIME STUDENT REQUIREMENTS
Same as full-time Student/**No** Physical Exam

INCOMING STUDENTS WHO RESIDE IN ON-CAMPUS HOUSING
Meningitis Vaccine must be vaccinated prior to moving into
on-campus housing (*menectra or menomune, menectra preferred*)

AGE EXEMPT REQUIREMENTS:
If living off campus:
Part time student born before 1957 need only a tuberculosis test (*PPD*)
Full time students born before 1957 need only a tuberculosis test (*PPD*) and physical exam
If living on campus:
Same as above plus meningitis vaccine requirement

Name: ____Date of Birth:_____/_____/_____
(Last) ***(First)*** ***(MI)***
Social Security or Student I.D. #: ___________________ Phone #: (   ) ______________________ E-mail: __________________

Address: ____
(Street) ***(City)*** ***(State/Country)*** ***(Zip Code)***

Campus or Local Address: ____

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY

Name: ____
(Street) ***(City)*** ***(State)*** ***(Zip Code)***
Phone Number: (______)-_______________________________________E-Mail Address: _______________________________

TO PARENTS AND GUARDIAN OF STUDENTS UNDER 18 YEARS OF AGE

I authorize the personnel of NJIT Health Services or authorized personnel of the University to proceed according to good medical practice in providing medical care of treatment to my child in an emergency or when unable to reach me for authorization.

Parent/Guardian's Signature: ____Relationship: ____________Date: ____/____/____

PERSONAL HEALTH ASSESSMENT: For the following questions, please check yes if you are presently having a problem or have had a problem in the past. If there is no significant problem, check no. Briefly explain all yes answers. ***TO BE COMPLETED BY STUDENT.***

Drug Usage: **Yes No**

Please give information about drug usage alcohol, marijuana, smoking…………… ❑ ❑

____

____

Cardiovascular:

Heart murmur/palpitations……………….….... ❑ ❑

Chest Pain…………………………………. ❑ ❑

Rheumatic fever……………………………. ❑ ❑

High blood pressure………………………. ❑ ❑

Irregular heartbeat…………………………. ❑ ❑

Blood clots (not menstrual clots)………….. ❑ ❑

Enlarge heart……………………………… ❑ ❑

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Respiratory:

Asthma……………………………………… ❑ ❑

Chest infection……………………………… ❑ ❑

Do you smoke cigarettes?............................ ❑ ❑

How many?______How Long?________

Shortness of breath………………………… ❑ ❑

Wheezing…………………………………… ❑ ❑

Skin:

Any problems with your skin?.................... ❑ ❑

Skin rashes…………………………………. ❑ ❑

____

____

Endocrine:

Thyroid disease……………………………. ❑ ❑

Diabetes…………………………………….. ❑ ❑

Urinary:

Impaired function of any part of your Urinary tract or loss of a kidney ❑ ❑

____

Kidney Stones:…………………………… ❑ ❑

Mental Health:

Any problems with your emotional health, requiring any form of therapy, including medications?.. ❑ ❑

Have you ever experienced a serious dietary problem (anorexia, bulimia, obesity) ❑ ❑

Medications:

(birth control pills, vitamins, over-the counter-medications and prescriptions): ❑ ❑

Amount:_____________________________

Usage Per day:________________________

Past Illness: **Yes No**

Hepatitis, mononucleosis, childhood diseases, malaria……………………… ❑ ❑

Loss or absence of any body parts. ❑ ❑

Severe/frequent colds or flu………… ❑ ❑

Hospitalization:

Have you ever been admitted to a hospital?... ❑ ❑

Have you ever had surgery?............... ❑ ❑

____

EENT:

Any problems with your eyes, ears, nose, or throat………………………………… ❑ ❑

Hearing impairment…………………… ❑ ❑

Loss of eye or eyesight………………. ❑ ❑

Blood:

Anemia………………………………… ❑ ❑

Sickle-cell disease………………….. ❑ ❑

Abnormal bleeding or bruising……..….. ❑ ❑

Bone and Joint:

Any serious disability deformity or disease of bone, joint, or muscle?.......... ❑ ❑

____

Neurology:

Seizures or convulsions………….. ❑ ❑

Fainting or blackouts……………… ❑ ❑

Dizziness……………………………. ❑ ❑

Gastrointestinal:

Problems with any part of your intestinal tract or stomach?.................................... ❑ ❑

Jaundice………………………………… ❑ ❑

Hernia…………………………………… ❑ ❑

_________________________________ ❑ ❑

Reproductive System (men):

Prostate trouble………………………… ❑ ❑

Swelling of the scrotum or testicle……. ❑ ❑

Undescended or absent testicle……….. ❑ ❑

Do you perform testicular self-examination?_____________________ ❑ ❑

Reproductive System (women):

Never had a menstrual period?............. ❑ ❑

Any form of menstrual disorder?........... ❑ ❑

Do you perform breast self-exam……… ❑ ❑

Last menstrual period______________

Allergy:

	Yes	No
Any significant allergy to food, medications, insects, pollen?..	❑	❑
Food? ………………………………………………………………………………….	❑	❑
Other? …………………………………………………………………………………	❑	❑

____

Family History:

Age and Health, if living, or Cause of Death:
Father:____
Mother:____
Brother:____
Sisters:____

Check the following diseases that have appeared among parents, grandparents, and siblings:

- ❑ Tuberculosis ________________________________
- ❑ Diabetes ___________________________________
- ❑ Cancer (type) _______________________________
- ❑ Seizure disorder _____________________________
- ❑ Stroke _____________________________________
- ❑ Heart disease ________________________________
- ❑ Kidney disease ______________________
- ❑ Emotional illness _____________________
- ❑ High blood pressure ___________________
- ❑ Problems with alcohol/drugs _____________
- ❑ Asthma ____________________________
- ❑ Other ______________________________

***Comments*:** ____

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To The Student:

I certify that the statements in Section 1& II are true to the best of my knowledge, and I consent to treatment in the Student Health Services with the understanding that all services rendered are confidential.

Student Signature: _______________________________________ Date:________/_______/______

PHYSICAL EXAMINATION
(Completed by physician)

TO THE PHYSICIAN: Please review the student's personal history and complete the form below. Comment on all abnormal findings. This student has been accepted at New Jersey Institute of Technology and this information will note his/her medical status. It will be used only as a background for providing health care. This information is strictly for the use of the Health Services and will not be released without the written permission of the students.

Name:____Date of Birth:____/____/____
(Last) ***(First)*** ***(MI)***
Height:__________________Weight_____________BP______________Pulse_____________________

Vision: Uncorrected Right ____________Left____________Corrected Right ___________Left __________

ASSESSMENT:

	Normal	Abnormal
1. Eyes …………………………………………………………………………..	______	_______
2. Ears …………………………………………………………………………..	______	_______
3. Nose, throat ………………………………………………………………..	______	_______
4. Neck/thyroid ……………………………………………………………….	______	_______
5. Chest, lungs ………………………………………………………………	______	_______
6. Cardiovascular ……………………………………………………………	______	_______
7. Abdomen, liver, spleen …………………………………………………….	______	_______
8. Genitalia, hernia ……………………………………………………………	______	_______
9. Nervous system, balance ……………………………………………………..	______	_______
10. Skin ………………………………………………………………………	______	_______
11. Musculosketetal …………………………………………………………..	______	_______
Upper extremity: AC joints, shoulder stability, symmetry, range of motion		
Spine: Neck-ROM, forward bend, curve ………………………………….	______	_______
Lower extremity: range of motion, symmetry ………………………………	______	_______
Ligaments, gait, knees, ankles ………………………………………………	______	_______
12. Psychological ……………………………………………………………	______	_______
13. Other ………………………………………………………………………	______	_______

ABNORMAL FINDINGS:

COMMENTS: Recommendations, continuing treatment, restrictions:
____
____
____
____

I have reviewed the clinical history as given by the student and after performing a physical exam, I certify that this student is able to participate in physical education and intramural activities without restrictions.

May ________________ May not _______________ Participation In ______________
(Name of Sport)

Examiner's Signature ____Date _____/_____/______

Print Name ____Phone #_______________

Address ____
(Street) ***(City)*** ***(State)*** ***(Zip Code)***