CAZENOVIA COLLEGE
MEDICAL FORM – History and Physical
Please Complete Both Sides

The information contained in the medical record is confidential and is intended for use by Health Service personnel only. It cannot be copied or transmitted without written permission.

Full Name_____ M ___F___
Address: _____
_____ DOB**:** _____
Cell Phone: _____ Email: _____
Parent Name(s):_____
Home Phone: _____Work Phone: _____
Health Insurance Co. _____
Emergency Contact Name: _____
Emergency Contact Number: _____

STUDENT HEALTH HISTORY: PLEASE CHECK ALL THAT APPLY AND EXPLAIN RESPONSES BELOW							
Abnormal Bleeding		Drug Use		HIV		Seizures	
Alcohol Use		Ear Trouble/Hearing Loss		Intestinal Trouble		Sexually Transmitted Infection	
Anemia		Eating Disorder		Irritable Bowel Syndrome		Sickle Cell Disease/Trait	
Anxiety		Eye Trouble/Visual Loss		Joint Problems		Skin Disorder	
Asthma		Fainting		Liver Problems		Sleep Problems	
ADD/ADHD		Genetic Disorder		Menstrual Problems		Thyroid Disease	
Cancer		Headaches – (frequent)		Missing Organs		Tobacco Use	
Chest Pain		Heart Murmur		Mononucleosis		Tooth/Gum Problems	
Chicken Pox		Heart Problems		Orthopedic Conditions		Tuberculosis	
Concussion		Heat Stroke		Pelvic/Vaginal Infections		Ulcer	
Depression		Hernia		Psychological Disorder		Undescended Testicle	
Diabetes		High Blood Pressure		Rheumatic Fever		Urinary Tract Problems	
Digestive Disorder		High Cholesterol		Scoliosis		Weight Loss/Gain	
Explain checked responses:							

Family History

	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Siblings				

Have any of your relatives ever had the following:

	Yes	**Relationship**
Alcoholism		
Asthma		
Diabetes		
Heart Disease		
Mental Illness		
Sudden Unexplained Death		
Other_____		

Have you ever been hospitalized or had any serious illness, injury or surgery; (please explain)_____
_____
received treatment or counseling for mental health reasons including substance abuse; (include dates and provider name)
_____
been unable to participate in sports/gym class for longer than a few days? (please explain)
_____

Medications Taken: (including herbals, vitamins, supplements, and birth control) **Dose:**

Allergies: (including to medicines)

Receiving Shots?____ How often?_____

The above information is accurate to the best of my knowledge. In the case of serious injury or illness, I authorize Cazenovia College representative(s) to secure medical care and/or hospitalization on my behalf. I authorize Health Service personnel to perform routine medical care as deemed necessary and to release information pertaining to safe participation in athletics to the athletic trainer. **I have reviewed information on Meningitis and the vaccine at www.cazenovia.edu, Health Services and**

□ I do not want the vaccine; □ I have an appointment to receive the vaccine; □ I received the vaccine within the last 5 years.

_____ _____ _____ _____
STUDENT SIGNATURE **DATE** **PARENT SIGNATURE (IF UNDER 18)** **DATE**

2/17

CAZENOVIA COLLEGE
PHYSICAL FORM

To be Completed by the Examining Healthcare Provider
***Physical must be within 1 year of beginning college**

PATIENT NAME _____ DATE of EXAM _____

Height _____
Weight _____
BP _____
Pulse _____
Temp _____

Vision: Right 20/ Left 20/ Both 20/ Corrected or Uncorrected
Urinalysis: Normal ____ Abnormal Values_____ _____ _____ _____ _____ _____
Hgb, if warranted _____ Cholesterol (recommended for family history of CAD) _____

Give details of each abnormality, use item number

	Check items as examined, enter "NE" if not evaluated	Normal	Abnormal
1.	Head, Neck, Face, Scalp		
2.	Nose and Sinuses		
3.	Mouth, Teeth, Gingiva, Throat		
4.	Ears – Canals, TM's, Hearing		
5.	Eyes – Lids, Pupils, Fundoscopic, etc.		
6.	Lungs, Chest		
7.	Breasts		
8.	Heart – Rate, Rhythm, Extra Sounds		
9.	Abdomen		
10.	Endocrine System		
11.	Genito-Urinary System – Testicular Exam, if male		
12.	Upper Extremities		
13.	Lower Extremities		
14.	Spine, Other Musculoskeletal Structures		
15.	Skin and Lymphatics – Acne, Dermatitis, etc		
16.	Neurological System		
17.	Gynecologic history – LMP Date_____ PAP Date _____		
18.	Psychological Status		

Recommendation for Physical Activity ☐ Unlimited ☐ Limited _____ ☐ Disqualified for Sports

Provide any recommendations for care of this student while away at college: _____
_____

Is this student currently under treatment for any medical or mental health condition? ☐ Yes ☐ No
Diagnosis: _____

Is this student currently on any medications, including birth control? (please list) _____
_____

Does this student require special housing or dietary accommodations while away at college? ☐ Yes ☐ No
If yes, give reason and supporting diagnosis_____

Has the Immunization Record been reviewed for required and recommended vaccines? ☐ Yes ☐ No
Has the Medical History Form been reviewed with the patient? ☐ Yes ☐ No

Stamp or Print Name _____ Provider Signature _____

Address _____
Phone _____
Date _____

Please return to: Cazenovia College Health Services, 10 Seminary St., Cazenovia, New York, 13035. If you have any questions, call 315-655-7122.

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