

ROSALIND FRANKLIN UNIVERSITY OF MEDICINE AND SCIENCE
STUDENT HEALTH AND MEDICAL HISTORY

DATE: _____

SCHOOL: CHP____ CMS____ SCPM____ SGPS____

STUDENT INFORMATION

Name: _____ Student ID Number: _____

Current Address:

Street _____
 City, State, Zip code _____
 Phone _____ E-mail _____

Permanent Address:

Street _____
 City, State, Zip code _____
 Phone _____ E-mail _____

Date of Birth: _____ Sex: _____ Country of Origin: _____

MEDICAL HISTORY

Any disease, disorder or problems with:

	Yes	No
Eyes, vision		
Ears, hearing		
Nasal		
Throat		
Headaches		
Neurologic		

	Yes	No
Lungs, breathing		
Heart		
Blood Pressure		
Blood Conditions		

Musculo-skeletal	Yes	No

Kidney	Yes	No
Bladder		

Skin Conditions	Yes	No

	Yes	No
Endocrine		
Pancreas		
Thyroid		
Other		

Men Only	Yes	No
Reproductive Organs		

Women Only	Yes	No
Menstruation		
Reproductive organs		
Pregnancy		
Breasts		

Please explain any of the previous categories you indicated "yes" to: _____

Surgeries /Serious Injury: _____

Any aspect of your health that present limitations or may require special arrangements: _____

Medications taken regularly by prescription or non-prescription: _____

Allergies to Food, Drugs, Air-borne, Insects: _____

Type of Allergic Reaction: _____

Allergy medication, injections: _____

Substance, Tobacco, Alcohol Dependence: _____

Infectious Disease (HIV, HepB, etc.): _____

MEDICAL EXAMINATION: To be completed by the examining physician

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

<i>Check each item in the appropriate column. Enter NE if not evaluated.</i>	Normal	Remarks or additional information
Abdomen		
Breasts		
Cardiovascular		
Dentition		
Ears, Hearing		
Eyes, Vision		
General Appearance		
Genitals		
Head		
Lungs/Chest		
Lymph nodes		
Musculoskeletal		
Neurologic		
Nose, Sinuses		
Pharynx		
Rectal		
Skin		
Thyroid		

Summary of defects and diagnosis: _____

Explain any condition that will prevent, limit, or require special arrangements for the student to participate in academic or physical activities: _____

Signature (MD,DO,PA)

Date

Printed Name

Address

City, State, Zip