



Health Questionnaire and Medical Exam Form

This questionnaire and the attached medical examination form (page 6) must be completed if you are entering Nursing or any other Allied Health program.

Please Print

_____	RCTC WSU	_____	_____
Student ID Number	(circle one)	Academic Program Name	Term/Year Beginning
_____	_____	_____	_____
Last Name	First Name	Middle Initial	
_____	_____	_____	_____
Home Address (number and street)	City	State	Zip
_____	_____	_____	_____
Date of Birth	Home Telephone	Work Telephone	
_____	_____	_____	
Person to notify in case of emergency	Relationship	Home/Business Telephone Number	
_____	_____	_____	
Health Insurance Company	Policy Number		

RCTC Student Health Services has information on a variety of health and wellness topics. Please complete the following if you would like more information on any of these topics.

I would like the following information

Mailed to my home address.

I will contact the Student Health Service to obtain this information.

<input type="checkbox"/> Birth control	<input type="checkbox"/> Smoking/Tobacco use
<input type="checkbox"/> Nutrition-weight control	<input type="checkbox"/> Blood Pressure
<input type="checkbox"/> Physical Fitness	<input type="checkbox"/> Alcohol & other chemicals
<input type="checkbox"/> Breast/Testicular self-exam	<input type="checkbox"/> Depression/Mental Health
<input type="checkbox"/> Sexually-transmitted diseases/AIDS	<input type="checkbox"/> Dental Care
<input type="checkbox"/> Stress	<input type="checkbox"/> Student Health Insurance

Health Service Office use only Date received: _____
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Student Name _____

Health Questionnaire

This questionnaire is confidential. No information from these two pages will be released without written consent.

For the following questions, circle Yes or No, whichever applies.

- Y N 1. Are you in good health?
- Y N 2. Has there been any change in your general health within the past year?
- Y N 3. Are you now under the care of a physician?
- Y N 4. Are you allergic to or have you ever reacted adversely to any prescription or non-prescription drug, food, additive, latex product, or insect bite?
If yes, which one(s) and what was the reaction? _____
5. Do you have or have you had any of the following diseases, conditions, or problems?
- Y N A. Heart murmur
If yes: Current or in the past? _____
Has it been evaluated? _____
Do you take antibiotics prior to dental work or surgical procedures? _____
- Y N B. Rheumatic fever or rheumatic heart disease
- Y N C. Congenital heart lesions, damaged heart valve
- Y N D. Heart trouble *Circle any that apply:* heart attack, angina, congestive heart failure, high blood pressure, irregular pulse, stroke
- Y N E. Trouble tolerating exertion
- Y N F. Respiratory or breathing problems
- Y N G. Tuberculosis, persistent cough, or cough up blood
- Y N H. Sinus trouble, asthma, hay fever
- Y N I. Blood disorder (anemia, hemophilia, leukemia), or blood clots (thrombophlebitis)
- Y N J. HIV+, AIDS, or an immunosuppressive disorder
- Y N K. Surgical prosthesis, (replacement part), shunt or transplanted organ
- Y N L. Recurrent headaches or a history of a severe head injury
- Y N M. Fainting spells, seizures, or epilepsy
- Y N N. Arthritis, inflammatory rheumatism (painful, swollen joints)
- Y N O. Chronic or recurrent skin conditions
- Y N P. Herpes - cold sores
- Y N Q. Stomach ulcers, Crohn's disease, Ulcerative colitis, irritable bowel syndrome, spastic colon, or other digestive problems
- Y N R. Hepatitis, jaundice or liver disease
- Y N S. Kidney trouble, hemodialysis, or frequent urination
- Y N T. Diabetes
- Y N U. Recent weight gain or loss (>10 lbs.)
- Y N V. Eating disorder diagnosis (anorexia, bulimia, compulsive overeating)
- Y N W. Psychiatric, mental, or emotional problems or diagnosis
- Y N 6. Have you ever required a blood transfusion?
If yes, explain the circumstances and the date. _____
- Y N 7. Have you had surgery, x-ray treatment or chemotherapy for a tumor, growth or other condition?
If yes, explain. _____
- Y N 8. Do you have any disease, condition or problem not listed above that you think we should know about?
If yes, explain. _____

Student name _____

Health Questionnaire (continued)

Y N Do you: a. use tobacco; if yes amount _____ type _____

Y N b. use alcohol; if yes amount _____ type _____

Y N c. use street drugs; if yes amount _____ type _____

Y N d. use caffeine; if yes amount _____ type _____

Y N 10. Have you ever received treatment or counseling for any of the above?

Y N 11. Do you exercise regularly (at least two times per week?)
If yes, type _____ frequency and duration _____

Y N 12. Have you ever felt abused physically, emotionally or sexually? _____

Y N 13. Have you ever been evaluated or treated for a sexually transmitted disease?
If yes what _____ year _____ treatment _____

14. How many sexual partners (male, female or both) have you had within past year? _____

15. How many sexual partners (male, female or both) has your partner had within the past year? _____

16. Have any of your blood relatives (parents, siblings, grandparents) ever had any of the following?

Y N Kidney disease

Y N Cancer

Y N Epilepsy

Y N Heart disease

Y N High Blood Pressure

Y N Bleeding disorder

Y N Arthritis

Y N Stroke

Y N Tuberculosis

Y N Diabetes

Y N Alcoholism

Y N Suicide

17. Have you ever been hospitalized for any reason?

If yes, list reason(s) and year(s) _____

18. Have you ever had surgery?

If yes, list type(s) and year(s) _____

19. Have you been under a physician's care within the past year?

If yes, describe _____

20. List all medications (prescription and non-prescription) you are currently taking, including vitamins and herbal remedies.

Women

Date of last pap smear _____ clinical breast exam/mammogram _____

Y N 1. Are you currently using birth control?

Y N 2. Are you currently using hormonal therapy?

Y N 3. Do you regularly examine your breasts for lumps or changes?

Y N 4. Are you pregnant?

Y N 5. Do you have any problems associated with your menstrual period?

Men

Y N 1. Do you regularly examine your testes for lumps or changes?

Please sign:

I certify that the above information is true and complete to the best of my knowledge.

Student Signature _____ Date _____

Student Name _____

Medical Exam Form

Please read carefully and sign:

I hereby grant Rochester Community and Technical College Student Health Services permission to share information contained on this Medical Exam Form with the appropriate academic program leaders and student affiliated clinical institutions. I understand that any health care costs incurred during the period of time I am a student at UCR will be my responsibility.

Student signature: _____ Date: _____

Please provide dates for the following vaccinations and tests. (See page 2 for requirement information.)

- ▶ Tetanus/Diphtheria _____
- ▶ Measles (Red, Rubeola) 1st _____ 2nd _____
- ▶ Mumps _____
- ▶ Rubella (German _____
- ▶ Hepatitis B 1st _____ 2nd _____ 3rd _____
- ▶ Chicken Pox (Varicella) Had disease? Yes No
- ▶ Mantoux (TB Skin Test) Most recent test date: _____ Updates: 1. Date: _____ Result: _____
or Chest X-ray: Result: _____ 2. Date: _____ Result: _____

The student's health care provider should complete the following sections.

Blood Pressure	Vision: Corrective lenses? Yes No Left 20/ Right 20/ Date of last eye exam	Hearing: Aid/equipment? Yes No Whispered voice heard? Left Right
Pulse Regular? Yes No		
Height Weight		

Are there any abnormalities, impaired functions, or disease conditions of the following? If yes, please explain.

1. Head	YES	NO	7. Genitourinary	YES	NO
2. Eyes	YES	NO	8. Musculoskeletal	YES	NO
3. Ears Nose Throat	YES	NO	9. Metabolic/Endocrine	YES	NO
4. Respiratory	YES	NO	10. Neurological	YES	NO
5. Cardiovascular	YES	NO	11. Psychiatric	YES	NO
6. Gastrointestinal	YES	NO	12. Skin	YES	NO

Are there any dermatological conditions that could be transmitted to a patient or co-worker, or cause breakdown and possible shedding in a sterile environment? Yes _____ No _____ If yes, please explain.

Is the patient now under treatment for any physical or emotional condition? Yes _____ No _____ If yes, please explain.

Do you have any recommendations for the health care of this student? Yes _____ No _____ If yes, please explain.

By history and physical examination, is this individual a carrier of any communicable disease? Yes _____ No _____ If yes, please explain. (Specific tests may be done but are not required.)

Recommendations for physical activity (lifting, bending, phy. ed., sports) Restricted _____ Unrestricted _____

Signature of Health Care Provider _____ Date _____

Clinic _____

Address _____

City _____ State _____ Zip _____

RCTC Student Health Services Use: Reviewed by _____ R.N. Date _____