



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. Has there been any change in your general health within the past year?
- Y N 2. Are you now under the care of a physician?
- Y N 3. 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? \_\_\_\_\_
4. 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 5. Are you in good health?
- 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 9. Have you ever been or are you currently in the military?
10. Do you use any of the following substances?
- Y N A. Tobacco: if yes, amount: \_\_\_\_\_ type: \_\_\_\_\_
- Y N B. Alcohol: if yes, amount: \_\_\_\_\_ type: \_\_\_\_\_
- Y N C. Street drugs: if yes, amount: \_\_\_\_\_ type: \_\_\_\_\_
- Y N D. Caffeine: if yes, amount: \_\_\_\_\_ type: \_\_\_\_\_
- Y N 11. Have you ever received treatment or counseling for any of the above?
- Y N 12. Do you exercise regularly (at least two times per week)?  
If yes, type: \_\_\_\_\_ frequency and duration: \_\_\_\_\_
- 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 the 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           |
- Y N 17. Have you ever been hospitalized for any reason?  
If yes, list reason(s) and year(s): \_\_\_\_\_
- Y N 18. Have you ever had surgery?  
If yes, list type(s) and year(s): \_\_\_\_\_
- Y N 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: \_\_\_\_\_
- Y N 21. Do you have any other health concerns you would like to discuss? \_\_\_\_\_  
\_\_\_\_\_

### 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):  
1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_

▶ Mumps: \_\_\_\_\_

▶ Rubella (German): \_\_\_\_\_

▶ Hepatitis B:  
1<sup>st</sup> \_\_\_\_\_  
2<sup>nd</sup> \_\_\_\_\_  
3<sup>rd</sup> \_\_\_\_\_

▶ Chicken Pox (Varicella):

Had Disease? Yes No

If no, date of vaccination: \_\_\_\_\_

▶ Influenza: \_\_\_\_\_

▶ Mantoux (TB Skin Test) or Chest X-ray:

Most recent date: \_\_\_\_\_ Result: \_\_\_\_\_

Updates 1.date: \_\_\_\_\_ Result: \_\_\_\_\_

2. date: \_\_\_\_\_ Result: \_\_\_\_\_

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

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

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 \_\_\_\_\_

Notes:

Signature of Health Care Provider \_\_\_\_\_ Date \_\_\_\_\_

Clinic \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_