NJIT New Jersey Institute of Technology

HEALTH HISTORY QUESTIONNAIRE PHYSICAL EXAMINATION

TO THE STUDENT: A health history, physical exam, and vaccination record (see immunization form) are required for all NJIT students prior to the start of the semester. Please review the "How to Submit Your Health Records" instruction sheet for submission deadlines. If your forms are not received by the required date, a ***HOLD*** may be placed on your future registration. **All information is confidential. Please review the privacy notice at https://www.njit.edu/healthservices/generalinfo/privacy-policy.php to review NJIT's privacy notice.**

NJIT ID #: _____ Phone #: ( ) _____ e-Mail: _____

Name: _____ _____ ____ _____

Last First (MI) Preferred Name

Date of Birth: __ __ / __ __ / __ __ Birth Gender: F M Gender Identity: _____

mm dd yy (circle one) (Optional; Fill-in)

Standing: Undergraduate / Graduate / Doctoral Status: Full-time / Part-time Residency: Off-campus / On-campus

Permanent Address: _____

(Street) ***(City)*** ***(State/Country)*** ***(Zip Code)***

Campus / Local Address:_____

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY

Name: _____

(Last) ***(First)*** ***(MI)***

Address: _____

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

Phone #: ( ) _____

PERMISSION FOR TREATMENT FOR STUDENT(S) UNDER 18 YEARS OF AGE.

When medical problems arise, we request that the following statement be signed by a parent or legal guardian: I hereby grant permission to the physicians and practitioner of St, Michael's Medical Center/NJIT- Student Health Services to evaluate, treat, or secure a referral to an outside agency for my son/daughter/ward in case of illness/injury. I also hereby grant permission to immunize my son/daughter/ward in cases where immunization is necessary as part of a treatment plan or when needed for prevention of illness.

Print Name: _____Relationship: _____Date: ____/____/____

Parent/Guardian's Signature: _____

NJIT ID #: _____ Name: _____ DOB:_____

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……	❑	❑
_____		

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_____		

NJIT ID #: _____ Name: _____ DOB:_____

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*:** _____

_____

_____

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:_____/_____/_____

NJIT 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 _____

Physical Examination:

	Findings		
	Normal	Abnormal	Description
Skin			
HEENT			
Neck			
Cardiovascular			
Respiratory			
Breasts			
Abdominal			
Genitourinary			
Musculoskeletal			
Neurological			
Psychological			

Allergies: List all know allergies and reaction for each

Allergy	Reaction

NJIT ID #: _____ Name:_____ DOB:_____

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)

Stamp: not valid without stamp

Provider Signature: _____

Print Name & Title: _____

Date: _____

Office Phone: _____