Plymouth State University
Health Questionnaire and Physical Form

Health Questionnaire

This Information is strictly confidential. Your knowledge and consent will be required for release of this medical record. Please fill out pages 1-3 completely and to the best of your knowledge. Do not skip any lines. Please check the appropriate "yes" or "no" box and fully explain any "yes" answers. Please provide insurance information and emergency contact information.

PART A: to be completed by student

Personal Information

Last Name_____ First_____MI ___
Home Address_____
Birth date_____ Citizenship_____

Father's name_____ Telephone # _____
Address_____

Mother's name_____ Telephone # _____
Address_____

Medical Insurance Information

Health Insurance _____Policy (Group)#_____
Subscribers name_____ ID # _____

Emergency Contact

Name_____ Relationship_____
Daytime phone_____ Evening phone_____

Do any of your blood relatives (parents, grandparents, siblings) currently have or ever had:

	yes	no	Relationship		yes	no	Relationship
Allergies				Fainting			
Anemia				Heart Disease			
Arthritis				High Blood Pressure			
Asthma				Migraine Headaches			
Cancer				Kidney Disease			
High Cholesterol				Intestinal Problems			
Depression				TB/Lung Disease			
Epilepsy/Seizures				Stomach Disease			
Heart Attack (under age 50)				Stroke			
Anything else not listed?				If yes, please explain			

Personal History: have you ever or do you currently have:

	yes	no		yes	no
Allergies			Fainting/Dizziness		
Anemia			Hearing loss		
Arthritis			Heart Disease/ Murmur		
Asthma			Hepatitis		
Bleeding (abnormal)			High /Low Blood Pressure		
Chest pain /Heart Attack			Intestinal Problems		
Cancer			Kidney Disease		
Colitis			Migraine Headaches		
High Cholesterol			Mononucleosis		
Depression			Skin problems		
Diabetes			Stomach problems		
Eating disorders			TB/Lung Disease		
Epilepsy/Seizures			Vision difficulties		

Injuries to the following areas					
Concussion/skull			Back/spine		
Neck			Hip /pelvis		
Shoulder/arm			Knee/Thigh		
Elbow/forearm			Ankle/ lower leg/ foot		
Wrist/hand			Rib/Chest		

If yes to any of the above, please explain	
Anything else not listed?	If yes, please explain

Any surgeries?_____ Date?_____
Explain_____

Any hospitalizations?_____ Date?_____
Explain_____

Are you currently taking any medications? Give names and dosage _____

Women Only

	yes	no		yes	no
Irregular periods			Severe cramps		
Breast lumps			Excessive flow		

Medications used_____

The undersigned, herewith certifies that the answers to the above questions are true.

Student's Signature_____ date_____

PART B: to be completed by Healthcare Provider

Last Name_____ First_____MI ___
Gender M F Height_____ Weight _____
Blood Pressure_____/_____ Heart rate _____
Visual Acuity L_____ R _____ Corrective lenses L_____ R _____ type:
Hearing acuity L_____ R _____

Exam: Are there any abnormalities or current injury to any of the following?
If yes, please explain below

	yes	no
Head, ears, nose, throat		
Respiratory/lungs		
Cardiovascular/heart		
Gastrointestinal		
Hernia		
Abdomen		
Genitourinary		
Neck/thyroid		
Neurological		
Skin		
Mental status		
Other		

	yes	no
Head		
Neck		
Shoulder/arm		
Elbow/forearm		
Wrist/hand		
Back/spine		
Hip /pelvis		
Knee/Thigh		
Ankle/ lower leg/ foot		
Rib/Chest		
Other		

_____

_____

Immunization Record: please list date of last immunization for:

Tetanus: _____ Hepatitis B: _____

MMR: _____ TB: _____

Recommendations for physical exertion/activity: _____ Unlimited _____ Limited (explain below)

_____

_____

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

_____ _____

Healthcare provider signature date

(print clearly or attach business card)
Healthcare provider name _____Telephone_____

Address_____