Bronx Community College
University Avenue & West 181 Street * Bronx, NY 10453
Health Services Loew Hall Rm. 101* 718.289.5858 * Fax 718.289.6074 * Alternate Fax 718.289.6347

PHYSICAL EXAMINATION FORM

Last Name____FirstName__________________________Middle Initial ____

Address____

Home Telephone #_________________________________Business Telephone #_____________________________________

Date of Birth______________________Date of Admission_____________

Sex: M__ F__ In Case of Emergency Notify _________________________ Telephone ____________________________

PERSONAL MEDICAL HISTORY: If your response to any of the following is **YES**, please provide additional details in the space provided.

YES	NO	
		1. Has there been any significant medical illness, injury, weight loss in the past 12 months
		2. Are you taking any medication? If yes, please list.
		3. Are you under a physician's care for chronic medical problems?
		4. Have you ever been an in-patient in a hospital?
		5. Have you ever had an accident causing disabling injury?
		6. Have you ever had a fractured bone?
		7. Have you ever had a surgical operation?
		8. Any history of a concussion, blackout, fainting, convulsion, recurrent dizzy spells, heat exhaustion / heart stroke?
		9. Do you wear eyeglasses, contact lenses, dentures or a hearing aid?
		10. Do you have any allergies to medications, foods, or the environment?
		11. Are you missing any organs or other body parts?
		12. Do you have a history of high blood pressure, heart disease, irregular heart rate, palpitations, diabetes, thyroid condition, liver, or kidney problems?
		13. Any history of sudden death in your family (under age 50)?
		14. Have you ever failed a physical examination for military service, employment, insurance or athletic competition?

LIFE STYLE QUESTIONS (TO BE ANSWERED BY THE STUDENT)	YES	NO
Do you smoke?		
Do you exercise regularly?		
Do you drink alcohol or take medication to relieve stress?		
Do you have a problem with your weight?		
Do you go for routine medical/dental checkups?		
Have you ever gone for cancer screening?		
Is your immediate family in good health?		
Have you or a member of your family ever been a victim of a violent crime?		
Have you ever used the emergency room for routine medical problems?		

Specify Type of Health Insurance Private Insurance____ Medicaid____ None____

Bronx Community College has a contract with Morris Heights Health Care Center located at 85 West Burnside Avenue, Bronx, New York 10453 whereby all registered students with out health insurance have access to the medical services offered at their facilities for a $10.00 co-payment. For an Appointment call (718) 483-1234.
A physical exam is not necessary for registration.

ALL INFORMATION ON THIS PHYSICAL EXAMINATION FORM IS CONFIDENTIAL AND CANNOT BE RELEASED WITHOUT A STUDENT'S WRITTEN CONSENT.

The preceding information is complete and correct to the best of my knowledge. I also authorize the release of this information and results of this examination to the Bronx Community College Department of Health and Physical Education.

_______________________________________ _____________________

Signature of Student Date

PHYSICAL EXAMINATION FORM

TO BE COMPLETED BY PHYSICIAN

Height ______/_____ Vision: O.D.__________O.S.__________
Weight_____________lbs. Blood Pressure:_____________mmHG

PPD Date:____________Result________

Chest X-Ray Date:____________ Result_______
(if PPD is Positive)

LAB WORK: Hct:_____________
Urinalysis: Glucose______________________Protein_______________________

RECOMMENDED FOR STUDENTS OVER 40: EKG__________ Chemistry______________

SIGNIFICANT MEDICAL HISTORY____
____

SIGNIFICAN MEDICAL HISTORY____

	Normal	**Abnormal**	**COMMENTS**
1. Head, Ear, Nose or Throat			
2. Respiratory			
3. Cardiovascular			
4. Gastrointestinal			
5. Hernia			
6. Eyes			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Allergies			

Depression Screening **Done** ☐ **Not Done** ☐ **COMMENTS**_________________________________

Do you have any recommendation regarding the care of this student? Yes ☐ No ☐

If yes, describe briefly____

Is the student now under treatment for any medical or emotional condition? Yes ☐ No ☐
If yes, describe briefly____

RECOMMENDATION for **Health & Physical Education class**: Full Activity ☐ Modified Activity ☐ No Activity ☐
Restrictions/Precautions: Explain____

RECOMMENDATION to **Participate in Competitive Athletics**: Full Activity Yes ☐ No ☐
Restrictions/Precautions: Explain____

Physician's Signature____

Address____

Telephone No.____

CLINIC STAMP REQUIRED BELOW

Date____

Revised on 7 /7/ 05