

REPORT OF MEDICAL HISTORY

PLEASE COMPLETE THIS BEFORE GOING TO YOUR PHYSICIAN FOR EXAMINATION

PERSONAL HISTORY (Please check if you have had any of the following)

- | | | |
|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Night Sweating |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glasses / Contact Lens | <input type="checkbox"/> Recent weight gain or loss/how much _____ lbs. |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injury / Concussion | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Hearing Aid (s) | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Back Problem | <input type="checkbox"/> Heart Problem / Murmur | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tonsillitis (Chronic) |
| <input type="checkbox"/> Convulsion | <input type="checkbox"/> Infectious Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Unexplained Aches & Pains |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Malaria | <input type="checkbox"/> Use smokeless / Chewing tobacco |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Smoke Cigarettes, Cigars or Pipe |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Migraine / Frequent Severe Headaches | How many years _____ |
| <input type="checkbox"/> Muscle Disorder | | How many a day _____ |

Other medical conditions that you believe we should be aware of ? (Please explain) _____

List any allergies _____

Have you ever been hospitalized ? Had any operations ? (please note details) _____

List all current medications _____
 List any serious injury _____

FAMILY HISTORY

	AGE	STATE OF HEALTH	OCCUPATION	AGE OF DEATH	CAUSE OF DEATH
FATHER					
MOTHER					
BROTHER (S)					
SISTER (S)					

Has any of your immediate family ever had any of the following ? (Please state relationship)

- Cancer _____
- Diabetes _____
- Heart Disease _____
- High Blood Pressure _____
- Kidney Problems _____
- Tuberculosis _____
- Other _____

I hereby certify that the information submitted on this record is complete and correct.

Signature of Student _____ Date _____

REPORT OF HEALTH EVALUATION

TO THE EXAMINING PHYSICIAN: Please review the student's history and complete the physician's form. Please comment on all positive answers. **THE STUDENT HAS BEEN ACCEPTED.** The information supplied will not affect his / her status: It will be used only as a background for providing health care, if this is necessary. This information is strictly for the use of the Health Services and will not be released without student consent.

SEX: F M

 LAST FIRST MIDDLE
 Blood Pressure _____ Height _____ Weight _____

Please check abnormalities of following systems:

Describe fully:

- | | | |
|--|---|--|
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Hernia | <input type="checkbox"/> Eyes |
| <input type="checkbox"/> Metabolic / Endocrine | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Musculoskeletal |
| <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Neuropsychiatric | <input type="checkbox"/> Head, Ears, Nose & Throat |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Skin | |

Are there any recommendations / limitations regarding care / physical activities for this student?
 (Physical Education, Intramurals) Explain: _____

Print Name _____

Address _____

Physician's Signature _____

RETURN ALL INFORMATION TO:
 Student Health Service
 Stevens Institute of Technology
 Castle Point on Hudson
 Hoboken, New Jersey 07030

WEBSITES YOU SHOULD KNOW:

For information about Student Health Services:
www.stevens-tech.edu/chs/health.htm

For information about Student Counseling Services:
www.stevens-tech.edu/chs/counseling.htm

For information about Student Health Insurance:
www.universityhealthplans.com and then click on "Stevens"

MENINGITIS SURVEY

This survey shall become part of the student's health record and is being required by N.J. Law, P.L. 2000 c.25.

Student Name (PRINT) _____

Social Security No. ____ / ____ / ____

I have read the above information about Meningitis, the effectiveness of the vaccine, and the availability of a meningitis vaccine.

Check one below:

- a. _____ I have decided to receive the meningitis vaccine now or at some future time.
- b. _____ I have decided not to receive the meningitis vaccine.
- c. _____ I am undecided about whether or not to receive the meningitis vaccine.
- d. _____ I have received the meningitis vaccine on ____ / ____ / ____ /

Administered by: _____ (Signature of Health Care Provider).

Signature _____
(Student or Parent/Guardian if student is under 18 years of age)

Date _____

NEW JERSEY STATE IMMUNIZATION REQUIREMENTS

New Jersey Law requires all students to submit documentation of immunity to measles, mumps, and rubella prior to registration. **Students who do not provide this information will be blocked from future registrations.**

- REQUIRED** > **MEASLES** (Rubeola) – **Two doses** of live vaccine given on or after the first birthday (and after 1968.) The second dose at least one month after the first.
- REQUIRED** > **MUMPS** – **One dose** of the vaccine given after 1968, and on or after the first birthday.
- REQUIRED** > **RUBELLA** (German Measles) - **One dose** of the vaccine given after 1968, and on or after the first birthday.
- REQUIRED** > **MENINGITIS** * - **One dose** of the vaccine is **MANDATORY for NEW students living in Stevens Residence Halls**. The vaccine remains optional for all other students at the current time.

This section must be completed and signed by a physician or health care provider OR a copy of you immunization records must be attached.

REQUIRED

MMR (Combined Measles, Mumps, Rubella Vaccine) Month/Day/Year MMR # 1 ____ / ____ / ____ MMR #2 ____ / ____ / ____

MEASLES (Single Antigen Measles Vaccine) Month/Day/Year 1 ____ / ____ / ____ ____ / ____ / ____

MUMPS (Single Antigen Mumps Vaccine) Month/Day/Year 1 ____ / ____ / ____ ____ / ____ / ____

RUBELLA (Single Antigen Rubella Vaccine) Month/Day/Year 1 ____ / ____ / ____ ____ / ____ / ____

* **MENINGITIS** (Meningococcal Meningitis Vaccine – Menomune – 1 dose) ____ / ____ / ____
*Required by NJ law for NEW students living in Stevens Residence Halls as of September 2004.

** **PPD – Mantoux Test** (Tuberculin skin test) – required for all students within the past 6 months, regardless of BCG history. PPD invalid without signature by provider, and the date read.

Test Date: _____ Date Read: _____ Results: _____ mm

Lot#: _____ Exp. Date: _____ MFR: _____

Copy of chest x-ray report required if > 10mm. induration (horizontal diameter).

INH prophylaxis taken? Yes ____ No ____ (If yes, please provide documentation.)

Prior PPD history: Date _____ Results _____ mm.

* * Required by Stevens Institute of Technology

RECOMMENDED – (Optional at the present time)

MENINGITIS ____/ ____/ ____ As noted above, this vaccine is MANDATORY for NEW students living in Stevens Housing as of September 2004. It is optional for all other students at the current time.

HEPATITIS B VACCINE: Series of 3 doses #1 ____/ ____/ ____

#2 ____/ ____/ ____

#3 ____/ ____/ ____

TETANUS / DIPHTHERIA: (within the last 10 years) ____/ ____/ ____

VARICELLA: (Chicken Pox) ____/ ____/ ____ ____/ ____/ ____

FORMS WITHOUT SIGNATURES AND THE REQUIRED INFORMATION WILL BE CONSIDERED INCOMPLETE

Signature of Health Care Provider _____

Print Name _____

Address: _____ Ph # _____ Fax # _____

Office Stamp: _____ Date: _____

Where can you obtain an acceptable record of your immunizations? Students are responsible for contacting the various agencies or institutions and requesting a copy of their immunization records.

All records MUST be in English or accompanied by a translation.

1. High School or previous Colleges - A copy of the immunization record may be obtained from your high school, Board of Education, or a previously attended college. These records may contain adequate information.
2. Personal Immunization Record - Records from pediatricians or family medical providers are acceptable, if verified (with stamp or signature), and contain proof of minimum requirements.
3. Local Health Department - If primary immunizations were received at a local health department, a copy may be obtained from this source.

EXEMPTIONS

(If you are applying for an EXEMPTION, please check below and provide the information indicated.)

- IMMUNE STATUS** - Measles, Mumps and Rubella antibody titers (Blood Test) Copy of laboratory results showing that you are immune is required. Only positive or immune titers will be accepted. Equivocal results are NOT acceptable.
- AGE** -Born prior to January 1, 1957 (valid for MMR exemption only)
- MEDICAL**- Physician statement required -must include diagnosis. If pregnant, statement must include your due date. (This exemption is reviewed to determine continuation of exemption.) You may be required to submit a physician statement annually.
- RELIGIOUS** - Statement explaining how these immunizations conflict with your religious beliefs is required.

MENINGITIS INFORMATION

By State Law, every incoming student must be provided with information about MENINGITIS and the availability of a vaccine to prevent Bacterial Meningitis. All incoming students (including re-admits) must complete and return the survey below.

All NEW students (residing in campus housing) as of September 2004 are required to show proof of one Meningitis Vaccination.

DEFINITION: Meningitis is an inflammation of the linings of the brain and spinal cord caused by either viruses or bacteria.

VIRAL MENINGITIS is more common than bacterial meningitis and usually occurs in late spring and early summer. Signs and symptoms of viral meningitis may include stiff neck, headache, nausea, vomiting, and rash.

BACTERIAL MENINGITIS occurs rarely and sporadically throughout the year, although outbreaks tend to occur in late winter and early spring. Bacterial meningitis in college-aged students is most likely caused by *Neisseria meningitidis* or *Streptococcus pneumoniae*. Common early symptoms include fever, severe sudden headache accompanied by mental changes, neck stiffness, and rash. Because meningococcal meningitis can cause grave illness and rapidly progress to death, it requires early diagnosis and treatment. In contrast to viral meningitis, persons who have had intimate contact with a case will require prophylactic therapy. Untreated meningococcal disease can be fatal.

INCIDENCE: About 2,600 people get meningococcal disease each year in the U.S. 10-15% of these people die, in spite of treatment with antibiotics.

PREVENTION: Meningococcal vaccine can prevent 2 of the 3 types of meningococcal disease in older children and adults. **The American College Health Association now recommends vaccination for all college-age students, (particularly those who live in dormitories).**

CONTACT YOUR HEALTH CARE PROVIDER FOR ADDITIONAL VACCINE INFORMATION.