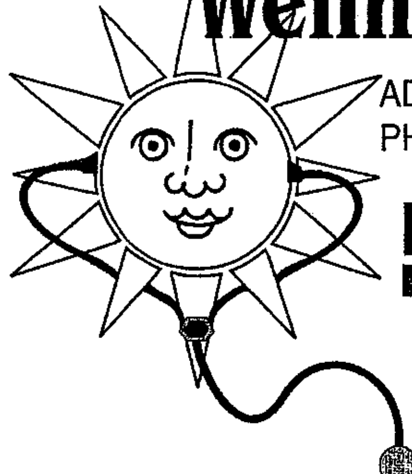
TO BE COMPLETED BY PATIENT
Check major for which applied:
☐ NURSING
☐ TEACHER EDUCATION
☐ HEALTH SCIENCES
(field)________________

CHICAGO STATE UNIVERSITY

HEALTH CENTER USE ONLY
Allergies____________________
____
____
____

Wellness/Health Center



ADMINISTRATION BUILDING, ROOM 131
PHONE 773 / 995-2010 • FAX 773 / 995-2953

MEDICAL RECORD

All information is strictly confidential

All students recently discharged from the military services may use a copy of their discharge physical if it was completed within 6 months of registration.

PLEASE PRINT ALL INFORMATION

Date of expected entrance ____________________ Social Security Number____________________

Name (Last, First, Middle) ____ Sex ☐ M ☐ F

Home Address ____________________ City/State ____________________ ZIP ____________

Phone number ____________________ Marital status ☐ S ☐ M ☐ D ☐ W

Age ______ Birthday: Month ____ Day ____ Year ________ Year in School: ☐ Fr ☐ So ☐ Jr ☐ Sr ☐ Grad

In case of serious illiness, please notify:

____

Relationship____________________ Telephone____________________

Are you covered by any type of hospitalization or medical insurance (such as Blue Cross-Blue shield, HMO, Medicaid or Medicare)?

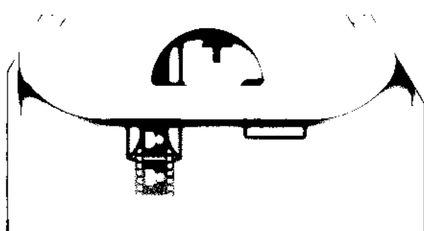
☐ No ☐ Yes Name of company ____________________ Identification number ____________________

PARENTAL PERMIT: The law requires that parental pemission be obtained for medical procedures on minors. The following consent should be signed by the parents or legal guardian so that ordinary medical care may be given without undue delay. However, no procedure will be performed without specific prior consent by parent or guardian.

*Consent: "**I hereby certify to the best of my knowledge that the preceeding is complete and correct.***

____________________do hereby authorize the Chicago State University Wellness/Health Center staff or their consultants to render whatever medical care they deem necessary for the health of (student's name) ____________________."

Date ____________ Signed ____________________ Relationship ____________________



HISTORY & PHYSICAL

DATE

NAME — M / F — MARITAL STATUS: S M W D SEP — DATE OF BIRTH

ADDRESS — PHONE (H) — (O)

OCCUPATION/ EMPLOYER — INSURANCE

PAGE # — CHART #

FAMILY HISTORY

IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

1) Epilepsy	6) Thyroid disease	11) Osteoporosis	16) Lipid disorder
2) Migraine	7) Hay fever	12) Arthritis	17) Alcoholism
3) Mental illness	8) Asthma	13) Heart disease	18) Hepatitis
4) Glaucoma	9) Anemia	14) Stroke	19) Cancer
5) Diabetes	10) Bleeds easily	15) Hypertension	20)

HOSPITAL ADMISSIONS

not including pregnancies

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING	ALLERGIES / SUPPLEMENTS	VACCINE	YEAR OF LAST	TEST / EXAM	YEAR OF LAST
	ALLERGIES	Tetanus / Td		Rectal / Stool	
		Influenza (flu)		Cholesterol	
	SUPPLEMENTS	Pneumonia		Eye	
		Hepatitis		Dental	
		Tuberculosis			

MEDICAL HISTORY

MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

MAIN PROBLEM

- ☐ Hearing problems ☐ Ringing in ear
- ☐ Dizzy spells ☐ Fainting spells
- ☐ Vision problems ☐ Eye pain
- ☐ Nose bleeds - *recurrent*
- ☐ Sinus trouble
- ☐ Sore throats - *frequent*
- ☐ Hoarseness - *prolonged*
- ☐ Hayfever / Allergies
- ☐ Pneumonia / Pleurisy
- ☐ Bronchitis / Chronic cough
- ☐ Asthma / Wheezing
- ☐ Shortness of breath: ☐ on exertion ☐ lying flat
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Heart murmur ☐ Swollen ankles
- ☐ Irregular pulse ☐ Palpitations
- ☐ Leg pain ☐ Cold numb feet
- ☐ Varicose veins / Phlebitis
- ☐ Loss of appetite ☐ Difficulty swallowing

- ☐ Heartburn ☐ Peptic ulcer
- ☐ Nausea / Vomiting ☐ Gallbladder dis
- ☐ Abdominal pain- *chronic*
- ☐ Jaundice / Hepatitis
- ☐ Diarrhea ☐ Constipation
- ☐ Diverticulosis ☐ Crohn's / Colitis
- ☐ Bloody or tarry stools
- ☐ Hemorrhoids ☐ Hernia
- Urination - Overactive Bladder
  - ☐ Overnight > than twice
  - ☐ More than 8 times / 24 hrs.
  - ☐ Urgency to urinate ☐ with leakage
- ☐ Decrease in force/flow ☐ Painful
- ☐ Stress incontinence-urine leakage with exercise / movement
- ☐ Blood in urine ☐ Kidney stones
- ☐ Urine infections ☐ Prostate prob
- ☐ Weight-loss - ☐ gain ☐ Height loss
- ☐ Appetite ☐ Nutrition problems
- ☐ Anemia ☐ Bruise easily
- ☐ Cancer ☐ Easily fatigued

- ☐ Diabetes ☐ Thyroid disease
- ☐ Seizures ☐ Stroke
- ☐ Tremor / hands shaking
- ☐ Numbness / tingling sensations
- ☐ Headaches - *frequent*
- ☐ Arthritis / Rheumatism
- ☐ Back pain - *recurrent*
- ☐ Bone fracture / joint injury
- ☐ Osteoporosis ☐ Gout
- ☐ Rashes ☐ Hives
- ☐ Psoriasis ☐ Eczema
- ☐ Concentration prob ☐ Sleep problems
- ☐ Depression ☐ Nervousness
- ☐ Moodiness ☐ Suicidal thoughts
- ☐ Memory loss ☐ Mental illness
- ☐ Rheumatic Fever ☐ Measles
- ☐ Chicken Pox ☐ Polio ☐ Mumps
- ☐ Tuberculosis ☐ German measles
- ☐ Herpes ☐ Aids / HIV ☐ STD
- ☐ Sexual problems / enjoyment

- ☐ Decreased life enjoyment
- ☐ Decreased work performance
- ☐ Alcohol ____ oz. per week
- ☐ Coffee / Tea ____ cups per day
- ☐ Smoking- cig/day # years year quit
- ☐ Exercise
- ☐ Street Drugs

FEMALES - *Please complete*

Menstrual flow:

☐ Reg. ☐ Irreg. ☐ Pain / Cramps

Days of flow ____ Length of cycle ____

Date -1st day of last period ____

☐ Pain / Bleeding during or after sex

Number of:

Pregnancies ____ Abortions ____

Miscarriages ____ Live births ____

Birth control method ____

☐ Flushing / Menopause

Date of last PAP test ____

☐ Normal ☐ Abnormal

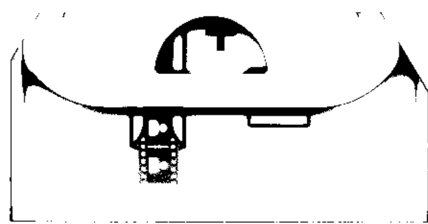
Date of last mammogram ____

☐ Normal ☐ Abnormal

SYNOPSIS

CHICAGO STATE UNIVERSITY

Printed by authority of the State of Illinois, July 2007



PHYSICAL EXAM

VITAL SIGNS HT WT BMI BP SUPINE BP SITTING PULSE RESP RATE TEMP °

VISION DISTANT (UNCORR) (R) (L) DISTANT (CORR) (R) (L) NEAR (UNCORR) (R) (L) NEAR (CORR) (R) (L) COLOUR VISION TONO METRY (R) (L)

OFFICE TESTS URINALYSIS - COLOR S.GR pH PROT GLUC KETO BILI BLOOD NITRITE UROB MICRO

Hbg STOOL O.B.

COMMENTS

GENERAL APPEARANCE

PHYSICAL EXAM POSITIVE/ ABNORMAL NEGATIVE/ NORMAL

☑ *POSITIVE OR ABNORMAL FINDINGS*
☒ *NEGATIVE OR NORMAL FINDINGS*

HEAD & NECK
- Head, Scalp ☐ ☐
- Lids-Sclera-Conj. ☐ ☐
- Eye Muscles ☐ ☐
- Pupils ☐ ☐
- Fundi ☐ ☐
- Ears ☐ ☐
- Nose / Sinuses ☐ ☐
- Teeth / Gums ☐ ☐
- Pharynx ☐ ☐
- Thyroid ☐ ☐
- Neck Glands ☐ ☐
- Carotid Bruits ☐ ☐

CHEST
- Chest-Lungs ☐ ☐
- Heart-Apex (location)
- Heart Sound ☐ ☐
- Murmurs / Thrills ☐ ☐
- Breasts & Nipples ☐ ☐
- Axillary Nodes ☐ ☐

ABDOMEN
- Abdominal Masses ☐ ☐
- Abdominal Tend ☐ ☐
- Liver /Spleen ☐ ☐
- Abdominal Bruits ☐ ☐

- Hernial Rings ☐ ☐
- Inguinal Nodes ☐ ☐

EXTREMITIES
- Pulses -Femoral ☐ ☐
- Popliteal ☐ ☐
- Post Tibial ☐ ☐
- Dorsalis Pedis ☐ ☐
- V. Veins ☐ Edema ☐ ☐
- Cyanosis ☐ Clubbing ☐ ☐

GENITO-URINE
- • ✦ Vulva / Vagina ☐ ☐
- Adnexae ☐ ☐
- Cervix ☐ ☐
- Uterus ☐ ☐
- Utero / Rectocoele ☐ ☐
- Pap Test (done) YES ☐ NO ☐ ☐ ☐
- Genitalia - (male) ☐ ☐
- - Prostate ☐ ☐

ANO-RECT
- Ano-Rectal ☐ ☐
- Sigmoidoscopy

DERM
- Skin Lesions ☐ ☐
- Nail Beds - Fingers ☐ ☐
- - Toes ☐ ☐

JOINTS
- ☐ ☐ Neck
- ☐ ☐ Shoulders
- ☐ ☐ Elbows
- ☐ ☐ Wrists
- ☐ ☐ Fingers
- ☐ ☐ Back
- ☐ ☐ Hips
- ☐ ☐ Knees
- ☐ ☐ Ankles / Feet

NEUROLOGICAL EXAM
- ☐ ☐ Paralysis
- ☐ ☐ Gait
- ☐ ☐ Muscle Atrophy
- ☐ ☐ Cranial Nerves
- ☐ ☐ Tendon Reflexes
- ☐ ☐ Romberg
- ☐ ☐ Babinski
- ☐ ☐ Sensory
- ☐ ☐ Motor
- ☐ ☐ Vibration
- ☐ ☐ Position
- ☐ ☐ Tremor
- ☐ ☐ Rigidity

INVESTIG
- ☐ CBC
- ☐ PSA
- ☐ TESTOSTERONE
- ☐ CHEST X-RAY
- ☐ ECG
- ☐ MAMMOGRAM

SYNOPSIS

PLANS

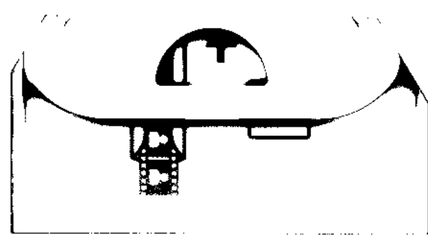
Signature of Student_______________ Date_______________

Signature of PCP / NP / MD_______________ Date_______________

PCP / NP / MD Name *(print)*_______________ Phone_______________

Address / City / State / Zip_______________

Received *(Date)*_______________ Reviewed *(Date)*_______________ By_______________



Student Immunization Record

This form is required to complete your college enrollment.

Name ____ ☐ Male ☐ Female
Last First Middle Initial

Permanent Address ______________________________ ☐ Apt # ______ ☐ Flr # ______

City ______________________ State ________ Zip ________

Day Phone ( ) ______________ Evening Phone ( ) ______________

Date of Birth (M/D/Y) ______ - ______ - ______ Social Security Number ______ - ______ - ______

Date of Enrollment:

☐ Fall 20 __ __ ☐ Springl 20 __ __ ☐ Fall 20 __ __

Status:

☐ Undergraduate Part Time ☐ Graduate Part Time
☐ Undergraduate Full Time ☐ Graduate Full Time
☐ Other ______________

Required Immunizations. Please provide the month, date, and year for every dose administered.

Immunization	Mo	Day	Yr	Mo	Day	Yr	Mo	Day	Yr	Mo	Day	Yr	Mo	Day	Yr
DPT (Diphteria, Pertusis & Tetanus)															
Td or TD (Diphteria & Tetanus)															
Combine MMR (Measles/Mumps/Rubella)															
Combined MR (Measles & Rubella)															
Rubeola (Red Measles) (Live Virus Vaccine)							**Disease Date** or **Titer Date:** (copy of titer must be attached)								
Rubella (3 day or German Measles)							Diagnosis of Disease is not acceptable. **Titer Date** (copy of titer must be attached):								
Mumps							**Disease Date** or **Titer Date:** (copy of titer must be attached)								

______________________________________ ______________________
Name of Provider and Address / City, State and Zip Phone Number

______________________________________ ______________________
Signature Date

Required Immunizations. Please provide the month, date, and year for every dose administered.

Immunization	Mo	Day	Yr	Mo	Day	Yr	Mo	Day	Yr	Mo	Day	Yr	Mo	Day	Yr
Oral Polio/PV															
HBV: Hepatitis B Vaccine															
Varicella: Chicken Pox						**Disease Date** or **Titer Date:** (copy of titer must be attached)									
Meningitis Vaccine				**Name of vaccine administered:**											

Tuberculosis PPD Mantoux* required for students not born in the US. This service is available at the Wellness Center.

Previous BCG?	Date Given	Date Read	Results in millimeter (mm) imduration	If positive, a US chest x-ray is required.
☐ Yes → Date ☐ No			mm	

Note: All students under 18 years of age must have parental permission before they may receive medical care at Chicago State University. We ask that you, the Parent/Guardian, sign this statement.
Parental consent for treatment: I, the Parent/Guardian, hereby give permission for the medical staff of Chicago State University to perform diagnostic, and therapeutic treatment, as they deem necessary.

______________________________________ ______________
Signature of Parent/Guardian of student under 18 Date

REVISED 6/30/03