Lincoln University Health Services
Health History & Physical Form

MANDATORY – <u>All</u> entering students **MUST** have a completed Personal Health History & Physical on file (incoming freshman, transfer students, and re-admits). Please complete this page before going to your physician for your examination. This information is strictly for Health Services use and will not be released without your knowledge and/or consent.

LAST NAME (PLEASE PRINT LEGIBLY) **FIRST NAME** **MIDDLE INITIAL** **COLLEGE ID NUMBER** **GENDER**

HOME ADDRESS **CITY OR TOWN** **STATE** **ZIP CODE** **DATE OF BIRTH**

STUDENT'S CELL PHONE NUMBER **STUDENT'S HOME PHONE NUMBER** **SEMESTER ENTERING (FALL OR SPRING)** **YEAR**

EMERGENCY CONTACT PERSON **RELATIONSHIP TO STUDENT** **HOME PHONE NUMBER** **CELL PHONE NUMBER** **WORK PHONE NUMBER**

DOES YOUR RELIGION PROHIBIT ANY TYPE OF MEDICAL TREATMENT? **YES** **NO**

Family History (The following questions relate to Parents, Grandparents, and Siblings)

	Age	Condition of Health	Occupation	Age at Death	Cause of Death			Yes	No	Relationship to Student
Father							Tuberculosis			
Mother							Diabetes			
Bro/Sis							Kidney Disease			
Bro/Sis							Arthritis			
Bro/Sis							Stomach Disease			
Bro/Sis							Asthma, Hay Fever			
Bro/Sis Bro/Sis							Epilepsy, Convulsions			

PERSONAL HEALTH HISTORY (Please answer all questions; comment on all positive answers on a separate sheet of paper)

HAVE YOU HAD	YES	NO	HAVE YOU HAD	YES	NO	HAVE YOU HAD	YES	NO	HAVE YOU HAD	YES	NO
Scarlet Fever			Insomnia			Pain and/or Pressure in Chest			Gallbladder Trouble or Gallstones		
Measles/ Rubeola			Frequent Anxiety			Chronic Cough			Recurrent Diarrhea		
German Measles/Rubella			Frequent Depression			Heart Palpitations			Recent Weight Gain or Loss		
Mumps			Worry or Nervousness			High or Low Blood Pressure			Dizziness and/or Fainting		
Chicken Pox			Recurrent Headaches			Rheumatic Fever or Heart Murmur			Weakness or Paralysis		
Malaria			Recurrent Colds			Disease or Injury of Joints			Venereal Disease		
Gum and/or Tooth Trouble			Head Injury w/Unconsciousness			"Trick" Knee or Shoulder			Stomach and/or Intestinal Trouble		
Hay Fever or Sinusitis			Tuberculosis			Back Problems			Frequent Urination		
Eye Trouble			Shortness of Breath			Tumor, Cancer, or Cyst			**Females Only:**		
Ear, Nose, Throat Trouble			Asthma			Jaundice			Irregular Periods		
Surgery:			Inhaler and/or Nebulizer Use			Seizure, Epilepsy			Severe Cramps		
Appendectomy			Name of Med			Anemia			Excessive Flow		
Tonsillectomy						Sickle Cell			**Birth Control**		
Hernia Repair			How Often Used			**Drug Allergies**			Depo Provera		
Any Other Surgery						**Penicillin**			Birth Control Pills		
Food Allergies			**Seasonal Allergies**			**Sulfonamides**			Nuva Ring		
			Allergy Injections			Serums			IUD		

	YES	NO
Has your physical activity been restricted during the past five years? (If yes, give reasons and duration)		
Have you had difficulty with school, studies, or teachers? (If yes, give details)		
Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problems? (If yes, give details)		
Have you had any illness or injury or been hospitalized other than already noted? (If yes, give details)		
Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years other than routine check-ups?		

STUDENT'S SIGNATURE (IF STUDENT IS A MINOR, PARENT OR GUARDIAN SIGNATURE IS REQUIRED) **DATE**

Lincoln University Health Services
Physical Examination Form

To The Examining Physician:
Please review the student's health history and complete the physical examination form. Please comment on all positive answers. The information supplied will be used for providing health care, if this is necessary. This information is strictly for the use of the Health Services Office and will not be released without student consent.

Last Name _____ **First Name** _____ **Middle Initial** _____ **Gender** _____

Temperature _____**Pulse** _____ **Respirations** _____ **Blood Pressure** _____ **Height** _____ **Weight** _____

Vision _____ **(Right Eye)** _____ **(Left Eye)** **Semester Entering:** ☐ **Fall** **or** ☐ **Spring** **Year** _____

Failure to complete and return this form will delay registration. Return of completed form is MANDATORY for ALL entering students.

MANDATORY VACCINES:

1. **Tuberculosis (Testing required within one year prior of admission) Date Administered:** _____ **Reading date & results:** _____
   (If positive result, must have a negative chest x-ray report attached. If QuantiFERON Gold test is done, must attach report) **negative or positive**
2. **DT or Tdap (Required within ten years of admission) Date:** _____
3. **MMR** **Date:** _____ **Date:** _____ **or Titer Report:** _____
4. **Varicella (Chicken Pox)** **Date:** _____ **Date:** _____ **or Titer Report:** _____
   (*Must have two vaccine dates or positive IGG report attached; history of having disease is not acceptable)
5. **Menactra (Meningitis) Date:** _____ **(Not required for commuters)**

RECOMMENDED: (For students who will possibly be exposed to blood and/or body fluids in a clinical and/or research setting)

Hepatitis B: **Dose 1:** _____ **Dose 2:** _____ **Dose 3:** _____

Polio: **Date Series Completed:** _____ **Date of last booster:** _____

Gardasil: **Dose 1:** _____ **Dose 2:** _____ **Dose 3:** _____

Influenza: **Last dose received:** _____

URINALYSIS OR URINE DIP STICK: **Glucose:** _____ **Ketones:** _____ **pH:** _____
Leukocytes: _____ **Nitrites:** _____ **Blood:** _____
If Indicated (Serum): **Hgb/Hct:** _____ **Glucose:** _____ **Na+:** _____ **K+:** _____

Are there any abnormalities of the following? (Use additional sheet of paper for positive answers)	Yes	No
1. Head, Ears, Nose, or Throat		
2. Respiratory		
3. Cardiovascular		
4. Gastrointestinal		
5. Hernia		
6. Eyes		
7. Genitourinary		
8. Musculoskeletal		
9. Metabolic/Endocrine		
10. Neuropsychiatric		
11. Skin		
Is there loss or seriously impaired function of any paired organ?		

Current Medications: _____ **Physical Restrictions:** _____

Do you have any recommendations regarding the care of this student? _____

Is the student currently under treatment for any medical or emotional condition? _____

Physician's Signature: _____ **Date:** _____

Address: _____

Print Last Name: _____ **Ofc Number**_____

Return completed forms to:
Lincoln University Health Services
1570 Baltimore Pike
Wellness Center, Suite 100
Lincoln University, PA 19352
Ofc: 484-365-7338 Fax: 484-365-7287
Healthservices@lincoln.edu

Lincoln University
Health Screening ~ Risk Assessment
Supplement Form (S1) ~ to be completed by ALL students

The following information is required for all students seeking admission to Lincoln University and/or residence on Lincoln University Campus. This information MUST be reviewed and signed by a licensed professional (Physician/Nurse Practitioner) prior to the individual's arrival on campus.

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Student ID Number _____

Please answer all of the following questions (If yes, please provide details on separate sheet of paper)

	Yes	No
1. Have you been in contact with anyone who has been diagnosed with the Ebola Virus?		
2. Have you been a caregiver for anyone exhibiting symptoms of the Ebola Virus? (Sudden onset of fever fatigue, muscle pain, headache and sore throat. This is followed by vomiting, diarrhea, rash, symptoms of impaired kidney and liver function, and in some cases, both internal and external bleeding (e.g. oozing from the gums, blood in the stools)		
3. Have you exhibited and/or been treated for any symptoms of the Ebola Virus in the past 90 days?		
4. Have you taken part in any ritualistic funeral ceremonies and/or handled any human remains or personal effects of any person infected with the Ebola Virus?		
5. Have you been in contact with any fruit bats of the Pteropodidae family, with the blood, secretions, organs or other bodily fluids of infected animals such as chimpanzees, gorillas, fruit bats, monkeys, forest antelope and porcupines found ill or dead or in the rainforest?		
6. Have you consumed any raw meat from any of the above wildlife?		
7. Have you traveled to or from Sierra-Leone, Guinea, Liberia, Nigeria, or Senegal within the past 90 days?		
8. Have you been in contact with anyone who has traveled to or from Sierra-Leone, Guinea, Liberia, Nigeria, or Senegal within the past 90 days?		

Student's Signature _____ **Date** _____
(If student is a minor parent/guardian signature is required)

Reviewing Physician's Signature _____ **Date** _____

Print Name _____

Address _____

_____

Telephone Number _____

Revised 2018