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Lincoln University Health Services
Health History & Physical Form

MANDATORY – All 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 (Please ✓)	Y/N		Y/N		Y/N		Y/N	
Scarlet Fever			Insomnia		Seasonal Allergies		Gallbladder Trouble or Gallstones	
Measles/ Rubeola			Frequent Anxiety		Pain and/or Pressure in Chest		Recurrent Diarrhea	
German Measles/Rubella			Frequent Depression		Chronic Cough		Recent Weight Gain or Loss	
Mumps			Worry or Nervousness		Heart Palpitations		Dizziness and/or Fainting	
Chicken Pox			Recurrent Headaches		High or Low Blood Pressure		Weakness or Paralysis	
Malaria			Recurrent Colds		Rheumatic Fever or Heart Murmur		Stomach and/or Intestinal Trouble	
Gum and/or Tooth Trouble			Tuberculosis		Disease or Injury of Joints		Frequent Urination	
Hay Fever or Sinusitis					Back Problems		**Females Only:**	
Eye Trouble			Shortness of Breath		Tumor, Cancer, or Cyst		Irregular Periods	
Ear, Nose, Throat Trouble			Asthma		Jaundice		Severe Cramps	
Surgery:			Inhaler and/or Nebulizer Use		Seizure, Epilepsy		Excessive Flow	
Appendectomy			Name of Med		Anemia		**Are you on birth control?**	
Tonsillectomy					Sickle Cell		If yes, what kind?	
Hernia Repair			How Often Used					
Any Other Surgery								

DO YOU HAVE ANY DRUG OR FOOD ALLERGIES? (example- penicillin, sulfonamides, etc.) If, so to what?

_____

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

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** _____

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)**

COVID-19 VACCINATION INFORMATION: Which vaccine did you receive? (circle answer) **MODERNA** **PFIZER** **JOHNSON & JOHNSON**

Date of 1st dose: _____ **Date of 2nd dose:** _____ **Booster date:** _____

***If you have a documented exemption, please notify the Office of Intuitional Equity to complete their form. disabilityservices@lincoln.edu ***

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? ☐ **Head, Ears, Nose or Throat** ☐ **Respiratory** ☐ **Cardiovascular** ☐ **Gastrointestinal**
☐ **Hernia** ☐ **Eyes** ☐ **Genitourinary** ☐ **Musculoskeletal** ☐ **Metabolic/Endocrine** ☐ **Neuropsychiatric** ☐ **Skin**

Is there loss or seriously impaired function of any paired organ? ☐ **No** ☐ **Yes** _____

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